TRICARE Program Management Organization

User's Guide

Version 2.0

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SECTION 1

TRICARE Program Management:
An Overview

- *TRICARE Management Activity Mission*
- *TRICARE and Program Management*
- *Program Management Organization Scope*
- *Program Management Organization Structure*
- *Program Management Organization Roles and Responsibilities*

1.1 TRICARE Management Activity Mission

The mission of TRICARE Management Activity (TMA) is to manage TRICARE; manage and execute the Defense Health Program (DHP) Appropriation and the Department of Defense (DoD) Unified Medical Program; and support the Uniformed Services in implementation of the TRICARE program and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). TRICARE provides comprehensive healthcare for active duty personnel, qualified family members, TRICARE-eligible retirees and their family members, and survivors of the uniformed services. The TRICARE Program is designed to:

- Offer beneficiaries a choice of healthcare delivery options that meet their unique situations;
- Complement healthcare services provided by the Military Treatment Facilities and Clinics;
- Expand access to care;
- Assure high quality standards of care;
- Control healthcare costs;
- Improve the readiness status for military personnel.

The Assistant Secretary of Defense for Health Affairs under the Under Secretary of Defense for Personnel and Readiness exercises authority, direction, and control over all DoD medical and dental personnel, facilities, programs, funding, and other resources within the Department of Defense.

1.2 TRICARE and Program Management

The Director, Defense Procurement recommended that the principles of Program Management, as found in the DoD 5000 series, serve as a basis for managing major TRICARE acquisitions. To meet that end, a Program Management Organization (PMO) was established to develop a centralized business approach using concepts from the DoD 5000 series. The PMO is now under the direction of the Deputy Executive Director, TMA. This centralized approach is used to manage not only healthcare contract acquisitions, but to also manage other complex TRICARE projects, reengineering efforts and demonstrations. The TRICARE Program Management structure outlined in this User's Guide:

- Creates clear lines of accountability and responsibility;
- Clearly identifies key stakeholders and shows relationships between functional sponsors or proponents and those responsible for deliverables;
- Centralizes responsibility for life cycle planning, integration and execution;
- Provides a mechanism for measuring success;

- Provides current and accurate status reports for the purpose of sound decision making;
- Provides common structure and disciplined processes that can be used for all projects, and/or demonstrations;
- Provides the ability to tailor projects and demonstrations with unique characteristics;
- Identifies mission needs by beginning with the end in mind.

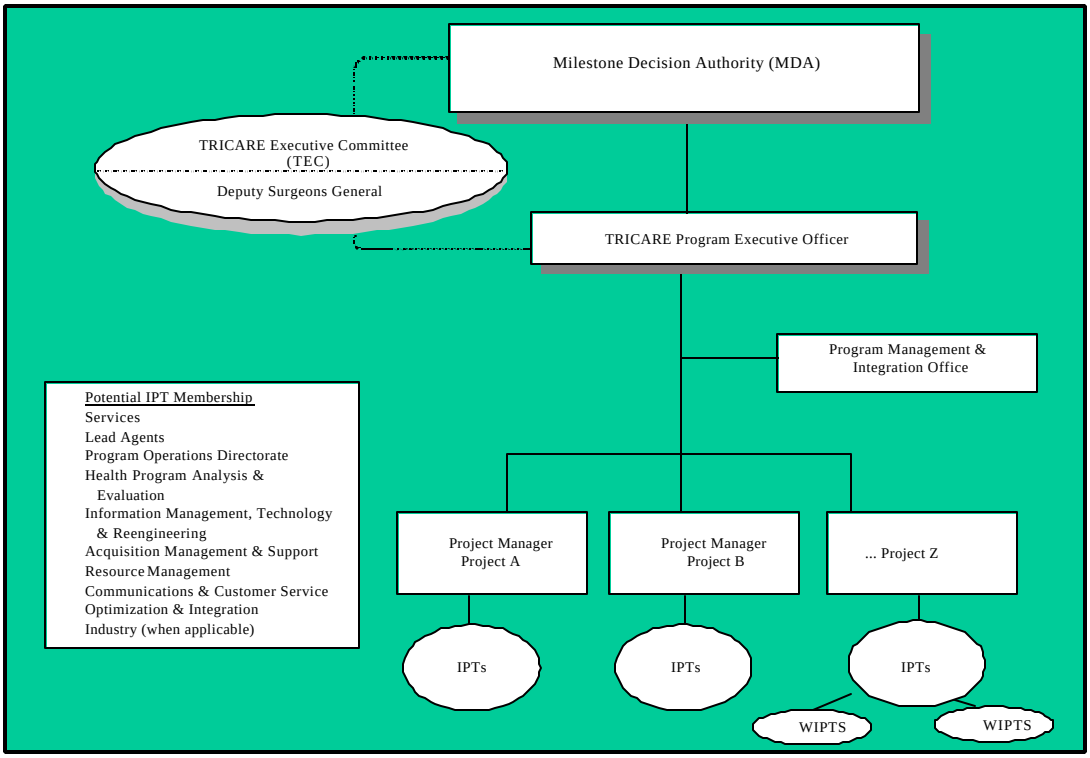
1.3 Program Management Organization Scope

A variety of programs and projects are well suited for the principles of program management. As a rule, TRICARE projects that typically fall under Program Management include new initiatives for healthcare delivery; legislatively mandated demonstrations; the award of TRICARE managed care support and other contracts; existing projects earmarked for re-engineering to better meet the needs of the Military Health System (MHS); and other new TRICARE projects as designated. Sponsorship for a project to be assigned to the PMO may come from TMA, Health Affairs, the Services, or a Congressional mandate. For general guidelines for determining if a project is appropriate for the Program Management Organization, **refer to Section 2.1**.

1.4 Program Management Organization Structure

The following chart **(Figure 1)** shows the functional Program Management Organization (PMO) structure under the direction of the TRICARE Program Executive Officer (PEO). The PMO process is coordinated within the TRICARE Program by the Program Management & Integration Office. Under the TRICARE Charter, the PEO is the Program Manager for TRICARE. All sub-activities are considered projects implemented under the direction of appointed Project Managers. 'Program Manager' and 'Project Manager' designations became effective with the TRICARE Charter, therefore samples included in this guide may reference previously acceptable titles.

Figure 1
TRICARE Program Management Functional Organizational Chart



1.5 TRICARE Program Management Organization Roles and Responsibilities

The TRICARE PMO integrates the systems, activities, participants and processes which are necessary to meet TRICARE mission requirements as identified by the TRICARE Milestone Decision Authority (MDA) and Program Executive Officer (PEO). The TRICARE PMO executes a program management model that combines the established TMA lines of executive authority with cross-functional participants from the Military Health System (MHS) and industry to provide a tailored program management organization utilizing DoD 5000.2-R guidance. The TRICARE PMO clearly identifies stakeholders and their corresponding responsibilities and centralizes TRICARE program management decision making to consolidate, integrate and prioritize requirements. The TRICARE PMO employs a disciplined, repeatable process that empowers working-level professionals to meet mission requirements and perform strategic analyses for timely executive-level decision making.

Milestone Decision Authority (MDA)

The ***TRICARE Milestone Decision Authority (MDA)*** is the final authority for all TRICARE related activities. The MDA approves the advancement of a project from one phase to another. The MDA provides direction, oversight and final approval for all projects.

TRICARE Executive Committee (TEC)

The ***TRICARE Executive Committee (TEC)*** serves as an advisory committee at the request of the MDA or the PEO. Its membership includes the Service Surgeons General. The TEC may serve as a sponsor or proponent for a project and as a liaison between Service constituents and the MDA, TMA, and/or PEO.

Deputy Surgeons General (DSGs)

The ***Deputy Surgeons General (DSGs)*** serve as a first level advisory committee and review projects and timelines as presented by Project Managers. The DSGs also provide input from the Service perspective through the nomination of Service representatives and participants.

TRICARE Program Executive Officer (PEO)

The ***TRICARE Program Executive Officer (PEO)*** is primarily responsible for oversight and management of the planning, integration, and coordination of one or multiple projects that fall under TRICARE Program Management. Depending upon scope and complexity, projects may be assigned to full-time Project Managers by the TRICARE PEO. The TRICARE PEO is accountable to the MDA for delivering a quality project on schedule and within cost. He/she

reports progress and issues regularly to the MDA. The PEO determines which projects will require oversight and assignment under Program Management.

TRICARE Resource Management Steering Committee (RMSC)

The ***TRICARE Resource Management Steering Committee (RMSC)*** membership includes Senior Comptrollers from each Service component served by the DHP. The TMA Deputy Director for Resource Management chairs the committee. In coordination with the Health Services Delivery Steering Group, the RMSC makes project funding recommendations. The group also reviews cost estimates submitted with change packages.

Health Services Delivery Steering Group (HSDSG)

The ***Health Services Delivery Steering Group (HSDSG)*** is comprised of senior representatives from each of the Services and TMA Chief of Staff. The group reviews updates from TRICARE Integrated Project Teams and ensures the respective DSGs are properly informed of TRICARE projects.

TRICARE Management Activity (TMA) Directors

The ***TRICARE Management Activity (TMA) Directors*** are responsible for the oversight and management of the TMA directorates. The Directors are accountable for the performance of the Project Managers from their directorates and are responsible for knowing Integrated Project Team progress through reports from their respective Project Managers and Integrated Project Team members. All TMA Directors will be assigned as a counselor to certain projects to monitor progress, track milestone achievement and provide guidance to the Project Managers.

Program Management Organization (PMO)

The ***Program Management Organization (PMO)*** is the management process that is used to structure and execute TRICARE projects. The PMO process was established to develop a centralized business approach using concepts from the DoD 5000 series and then was tailored to TRICARE.

Program Management & Integration (PM&I) Office

The ***Program Management & Integration (PM&I) Office*** provides an approved program management model for TRICARE and adds structure and processes, where appropriate, to meet the execution and integration requirements of projects assigned under the TRICARE PMO discipline. This office provides consultants to facilitate issue resolution, monitor project development and track timelines/milestones. Reports and updates are provided on a routine basis to the PEO to obtain

concurrence. When appropriate, the PM&I staff facilitates the integration of PMO projects to ensure all aspects of TRICARE projects are supportive and complementary.

Project Manager (PM)

The ***Project Manager (PM)*** is appointed in writing by the PEO. The PM is responsible for the planning, integration, management and execution of day-to-day activities associated with meeting the project mission, schedule, cost, and deliverables. He/She is ultimately responsible for the completion of mandatory and discretionary documents and activities, and reports project progress to the PEO on a regular basis. The PM coordinates issue resolution through the Integrated Project Team appointed to the project. The PM determines the team composition, meeting frequency and strategic direction. Consultation with the Director, PM&I is available as needed.

Project Coordinator (PC)

The ***Project Coordinator (PC)*** is assigned to a particular project by the PM&I Office. The PC is responsible for providing quality program management support by assisting the PM with the activities, issues, decision making, communications, reporting and overall management of the Integrated Program Team. The PC provides analytical, technical, and logistical support by documenting and tracking project activities, deliverables and briefing schedules. The PC consults with the PM on a regular basis to assist with the project's day-to-day activities. PC support functions cease when Integrated Project Team work is completed.

Integrated Project Team (IPT)

The ***Integrated Project Team (IPT)*** facilitates teamwork and collaborative decision making to generate recommendations related to the assigned project objectives. Each member represents a functional area or contributes subject matter expertise to meet the project deliverable. Composition will be determined by the scope and complexity of the project, along with staffing needed to support the PM in the management of the project. Membership on the IPT consists of senior staff officers within the TMA Directorates, Services, and Lead Agent Offices and other organizations as identified by the PM.

Working Integrated Project Team (WIPT)

The ***Working Integrated Project Team (WIPT)*** is responsible for specific issue resolution as assigned by the PM. Potential issues are forwarded to the PM for dissemination to the WIPT chair. WIPTs are appointed and empowered by their work area and participate in resolving specific issues related to the PMO project. WIPTs may work a specific issue for the IPT and present a recommended solution and/or alternatives for IPT consideration and action.

TRICARE Management Activity (TMA), Services and Lead Agents (LAs)

The ***TRICARE Management Activity (TMA), Services and Lead Agent (LAs)*** are responsible for providing qualified, empowered staff to participate in the TRICARE PMO project as IPT or WIPT members. As team members, this staff may be asked to determine joint requirements, provide schedules and project deliverables, facilitate various sub-projects, and evaluate or provide comments on projects at various stages of delivery. These representatives are expected to serve as liaisons to their appointing organizations and to coordinate feedback with the Director and PMs at regularly scheduled intervals.

SECTION 2

Program Management Organization Process

- *Identification of a Program Management Organization Project*
- *Selection/Appointment of a Project Manager*
- *Project Manager Roles and Responsibilities*
- *Project Coordinator Responsibilities*
- *Identification of an Integrated Project Team*
- *Identification of Working Integrated Project Teams*
- *Project Closeout*

2.1 Identification of a Program Management Organization Project

The Milestone Decision Authority (MDA) or Program Executive Officer (PEO) will identify which projects will fall under (PMO) oversight and supervision **(See Section 1.3)**. The PEO will select and/or appoint a PM based on experience, knowledge, and complexity of the project. The PM will determine the scope of the project for the Director, PM&I Office to assist with planning activities for the project and assignment of support staff.

2.1.1 Program Management Organization Project Criteria

General guidelines for determining if a project is appropriate for Program Management include meeting the following criteria.

- The project has a definable beginning and end point, follows a life cycle from start to completion, and is defined as a project requiring input from many sources versus an individual task or process improvement activity.

- The project is more than moderately complex resulting in medium risk to the success of the TRICARE mission.

- The project is identified by either the MDA or the TRICARE PEO as requiring program management oversight.

2.1.2 Accelerated Projects

Some initiatives requiring program management oversight do not fit the classic PMO definition of a project. To ensure we recognize these requirements as they arise and to facilitate our accomplishment of the mission, the guidance for accelerated projects is provided. The structure described below is somewhat more flexible than the more deliberate Program Management framework, and allows the Project Manager and associated action officers more latitude in developing schedules, meeting short-term requirements and reporting on milestones over a more condensed time period.

To meet the criteria for designation as an accelerated project, either the MDA or the TRICARE PEO identifies the initiative as requiring program management oversight and the initiative typically has the following characteristics:

- Short term estimated completion date, i.e., less than 90 days;
- May not reflect a typical project life cycle model, i.e., distinct phases as described in the PMO process;

- Input required from many sources versus an individual task or process improvement activity;
- Definable end product and/or deliverable;
- Project Initiative is more than moderately complex resulting in at least medium risk to the success of the TRICARE mission.

2.2 Selection/Appointment of a Project Manager

Once a project has been identified for the PMO process, the PEO will appoint a Project Manager (PM) to head up the new project. The PEO will send an appointment letter **(Sample A)** notifying the member of his/her assignment. This appointment may be coordinated and discussed with other TMA Directors before a formal appointment letter is sent. Depending on the scope of the project, a Co-Project Manager or Deputy Project Manager may be assigned to provide additional management support. The PM&I Office will assign both a primary and secondary Project Coordinator to work with the PM and provide program management support.

SAMPLE A - PROJECT MANAGER APPOINTMENT LETTER

MEMORANDUM FOR COL GEOFFREY RAKE, OPTIMIZATION AND INTEGRATION

SUBJECT: Program Manager Appointment for Specialized Treatment Services/Centers of Excellence IPT

You are hereby appointed the Program Manager for the Specialized Treatment Services/Centers of Excellence (STS/COE) IPT. You will be guided in your duties and responsibilities by the Department of Defense Regulation 5000.2-R and the TRICARE PMO User's Guide. The Director, Program Management and Integration Office, will provide copies of both of these documents to you during your "kick-off" briefing. The program will develop a strategy for full implementation of mandatory criteria agreed upon by TMA, the Services, and civilian experts for those facilities designated as “Centers of Excellence”.

As the TRICARE Program Manager for STS/COE, you are responsible and accountable for coordinating the day-to-day activities of the program and for ensuring that the program progresses satisfactorily through the tailored TRICARE Program Management Organization (PMO) model. The Program Manager periodically reports status and progress to the TRICARE Program Executive Officer (PEO).

As the STS/COE Program Manager you are specifically responsible for:

- serving as the Chair of the STS/COE Integrated Program Team (IPT);
- managing the program in a manner consistent with the policies and principles articulated by the TRICARE PEO;
- briefing the IPT recommended program schedule to the TRICARE PEO for approval;
- providing assessments of program status and risk reporting variances to the TRICARE PEO;
- monitoring cost, performance and schedule;
- managing the risk for the program by allocating resources, executing risk management, and ensuring interaction and communication between team members;
- overseeing the development of the necessary program and acquisition documentation to execute the program (e.g., Mission Needs Statement, Program Management Plan, etc.);
- ensuring that the appropriate stakeholders are actively engaged in the program;
- representing the program at intra-agency and inter-agency meetings;
- coordinating program actions with the other organizations as necessary.

This assignment expires when a comprehensive plan with a complete DODI is accomplished, or, at the request of the TRICARE PEO.

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

cc:
Ms. Cheryl Kaminska
CAPT John Aguilar

2.3 TRICARE Management Activity Project Manager

Roles and responsibilities applicable to Project Managers (PMs) across all projects are bulleted in the sample appointment letter (Sample A). Though project accountability remains with the PM, the expectation is for the PM to use all available resources, such as, IPT stakeholders, Project Coordinators (PCs) and other TMA assets, to assist in mission accomplishment. Below is a more detailed listing of a successful PM's profile, roles and responsibilities.

2.3.1 TRICARE Management Activity Project Manager Profile

TMA PMs are senior leaders who have demonstrated strong organizational skills and have a record of proven top performance. They have the confidence and support of their nominating Director and should quickly acquire or hone appropriate program management skills. To assist PMs in the endeavor, requisite training will be provided as necessary. Key ingredients of the successful PM include the following:

- General knowledge of DoD 5000 methodology.
- Understanding of the Program Management process as applied to TMA
  - Work Breakdown Structure (WBS)
  - Task lists
  - Risk management
  - Phased planning/milestone driven method
- Understanding of TMA hierarchy, chain of command and approving bodies.
- Commitment to the project mission.
- Team coordination and consensus building.
- Proactive attitude toward project issue resolution.
- Time management skills.
- Communication and analytical skills.
- Results driven mind-set and an ability to multi-task.
- Long term and big picture perspective.
- Ability to delegate appropriately.
- Effective meeting management skills.
- Effective use of VTC, teleconferencing, web-based and in-person meetings.

2.3.2 Project Manager Roles and Responsibilities

<u>Requirements</u>

- Clearly delineate IPT goals, deliverables and timeline.
- Identify appropriate personnel to participate in and/or advise IPT.
- Spearhead and coordinate IPT activities to generate project requirements and recommendations.

- Survey information on related initiatives both within and outside TMA.
- Assess current organizational systems and identify areas needing expansion or reform.
- Evaluate strategic, financial, political and technological risks associated with project requirements and timeline.
- Ensure appropriate and consistent communications occur among IPT.
- Delegate tasks to IPT members and project support personnel to optimize IPT activities.
- Establish and monitor the progress of WIPTs.
- Generate core documents reflecting project objectives & requirements, timeline, budget constraints, technological interfaces and implementation plan.
- Review direct care system and managed care support contract implications.
- Draft policy, memorandums, legislative language and managed care support contract modifications required to implement project recommendations.
- Apply TMA marketing capabilities, i.e. Communications & Customer Service (C&CS) Directorate as needed.

Briefings

- Update chain of command on project status at scheduled or appropriate intervals.
- Create concise, relevant and timely briefs for executive decision bodies (e.g. TMA Directors, Program Executive Officer, Deputy Surgeons General) outlining IPT progress, budget requirements, critical decision points and project stoppages.
- Staff project proposals through TMA Directorates and Services for comment prior to finalization of recommendations.
- Be prepared to brief relevant outside agencies as directed, e.g., Office of the Secretary of Defense (OSD), Medical Personnel (MEDPERS).

Funding & Resources (as appropriate)

- Assess direct care impacts at Military Treatment Facility (MTF) and regional level.
- Quantify purchased care impacts over life of Managed Care Support Contract (MCSC).
- Develop team of subject matter experts, government contracting staff and MCSC representatives to review/verify project requirements and formulate a PM's Cost Estimate based on contractor Rough Orders of Magnitude (ROMs), Independent Government Cost Estimates (IGCEs) or other government sources.
- Enlist the services of contractors to obtain third party cost estimates and assessments.

- Review technology based initiatives with Information Management, Technology & Re-engineering (IMT&R) Directorate and address IMT&R Functional Integrated Workgroup (FIWG), if appropriate.
- Submit cost estimates for Program Objective Memorandum (POM), i.e., the out-years.
- Identify funding stream and coordinate through TMA Resource Management Directorate.
- Consider costs related to the continuance of the project after the close of the IPT.
- Align project funding approval and subsequent implementation target dates with Planning, Programming and Budget System (PPBS).
- Submit fact sheets for Contracted Advisory Assistance Services (CAAS) and non-CAAS budget requirements, i.e., near-term requirements.
- Identify Program Management & Integration (PM&I) Office funded activities and non-PM&I funded activities.
- Review cost estimates from third party contractors, government team and MCSC to determine project cost estimate for Change Management Board (CMB) approval.
- Monitor project costs during contractor negotiations with assistance from Contracting Officer (CO). Obtain CMB approval for increases greater than 10%.

Project Implementation

- Coordinate with Resource Management (RM) Directorate to verify Form 789 authorizing Acquisition Management & Support (AM&S) Directorate and Program Operations Directorate (POD) to start work, is completed and forwarded.
- Identify and work closely with assigned Change Cycle Manager and CO to definitize project requirements, effectively communicate requirements to contractor, maintain within appropriate cost parameters and remain on schedule.
- Notify CO when communications with MCSCs is warranted.
- Continue to update costs and monitor project requirements for changes approved for out year funding.
- Develop negotiating/pricing IPT to work with MCSC to negotiate contract change.
- Ensure questions appropriately answered and understanding of change requirements consistent between government and MCSC.

Project Closeout

- Celebrate accomplishments and successes of IPT activities.
- Identify any issues that are outside the mission or scope of the IPT and need further attention or development.
- Develop recommendations for long-term maintenance of project initiatives including, cost estimates, assignment of organizational responsibility, operational procedures and performance metrics.

- Formally closeout project by briefing PEO and obtaining approval signature.
- Confirm termination date of support activities with Director, PM&I Office.
- With assistance of PC, create closeout summary binders for PM and Director, PM&I Office.
- Generate letters of appreciation and completion certificates for project participants, as appropriate.

2.3.3 Project Manager's Checklist

The PMO User's Guide outlines the steps to successful project completion. The Project Manager's Checklist is a tool to assist the PM in tracking tasks and reporting requirements within a phase.

PROGRAM MANAGEMENT ORGANIZATION (PMO) GUIDE
PROJECT MANAGER'S CHECKLIST

PRE-PHASE – DETERMINATION OF MISSION NEED	**SECTION**
❑ Project Manager Appointment	2.2
❑ Project Manager Appointment Letter	2.2
θ PMO Kick-off Meeting with PM&I Director And Project Coordinator	4.2
❑ Project Coordinator Roles & Responsibilities	2.4
❑ Funding	6, 5.4
❑ Review of PMO process and required documents; PMO Guide	4.2
❑ Project Charter (if applicable)	3
❑ IPT Nominations	2.5
❑ IPT Membership	2.5.1 or 2.5
❑ Mission Needs Statement	3.1.1
❑ Project purpose and scope	3
❑ Project priorities and goals	3
θ IPT Review Briefing	4.4
❑ Milestone 0 Briefing - Mission Validation & Approval	4.5
PHASE 0 - CONCEPT EXPLORATION	**SECTION**
❑ IPT Meetings	2.5.1
❑ Task Assignment	2.6
❑ Submission dates	2.5.2
❑ Meeting schedule	2.5.2
❑ Business Plan	3.3
❑ Milestone Chart	3.2
❑ Preliminary Primavera v3 (P3) Chart	3
θ IPT Review Briefing	4.4
❑ Milestone I Briefing – Approval of Concept	4.5

PROGRAM MANAGEMENT ORGANIZATION (PMO) GUIDE
PROJECT MANAGER'S CHECKLIST

PHASE I - PROJECT DEFINITION AND RISK REDUCTION	SECTION
θ Functional Requirements	5.3.1.2
θ Project Management Plan (PMP)	3.4 or 3.5
❑ Funding	3.4
❑ Metrics (preliminary)	3.4
❑ Risk Assessment (technical and programmatic)	3.4
❑ Acquisition Strategy	3.4
❑ Revised Primavera v3 (P3) Chart	3
❑ IPT Review Briefing	4.4
❑ Milestone II Briefing-Approval of Plan	4.5
PHASE II - MATURE & FINALIZE DESIGN/PROCESS	**SECTION**
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PHASE III - TRANSITION IN IMPLEMENTATION/OPERATIONS SUPPORT	**SECTION**
❑ Evaluation Activities	2.3.3
θ Maintenance Activities	2.3.4
❑ Milestone IV Briefing - Approval of Transition Plan (optional)	4.5
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❑ Closeout Project	2.3.4 or 2.7
❑ Brief PEO	2.7.1
❑ IPT Final Binder	2.7.2
❑ Appreciation Letters	2.7.3
❑Project Manager	2.7.3
❑IPT Members	2.7.3
❑Project Coordinator	2.7.3

2.4 Project Coordinator Responsibilities

The primary role of the Project Coordinator (PC), is to assist the Project Manager (PM) by providing program management support. The PC communicates with the PM on a regular basis to help with the daily activities of the project. The PC's responsibilities include, but are not limited to:

- Preparing core documents for PM approval including the Mission Needs Statement, Business Plan, Milestone Chart, and Project Management Plan;
- Monitoring and updating project schedules;
- Identifying stakeholders;
- Scheduling and facilitating IPT meetings to include drafting IPT meeting agenda and maintaining minutes of the meetings acknowledging attendees and clearly indicating any decisions agreed upon and any dissenting votes;
- Ensuring a "working issues matrix" of all issues is recorded, including entry dates, resolution dates and a description of actions taken;
- Assisting the PM by ensuring status reports and issues requiring senior level input are forwarded to the next appropriate level in the IPT structure, i.e., PM and Director, PM&I;
- Drafting IPT Review Briefings, Milestone Approval Briefing, and other briefings as needed for PM;
- Potentially supporting and coordinating WIPT activities with IPT members;
- Researching and analyzing proposed policy recommendations;
- Assisting with the development of marketing materials;
- Acting as informational liaison between IPT members, TMA, PM&I staff, and the PM;
- Drafting, coordinating and maintaining accurate project information for the website;
- Developing a good working relationship with the PM;
- Promoting integration of separate projects as applicable;
- Drafting project closeout documentation. **(See Project Closeout Section 2.7)**

2.5 Identification of an Integrated Project Team

The purpose of the Integrated Project Team (IPT) is to facilitate teamwork and collaborative decision making by generating recommendations based on timely input from an entire competency team. Using an IPT approach, each functional expert participates in the decision making process, working on the project and its deliverables to meet the goals identified in the mission needs statement.

2.5.1 Nomination/Appointment of Integrated Project Team Members

Each IPT should be composed of appropriate, diversified team members working together for the success of the project and enabling the PM and other decision makers to form correct, informed decisions at the proper time, while directing the project to completion. It is recommended that IPT membership be kept to a manageable size of approximately 8-10 members, however size may vary depending upon the specifics of the project. Cooperation within the IPT is essential; open frank discussions with full disclosure are imperative.

The PM, with the assistance of the PC, is responsible for distributing IPT nomination letters **(See Sample B)** to the Lead Agents, Services, and TMA Directorates or other organizations. Nominations are based on requisite knowledge, expertise and overall ability to address the development and implementation of the functional and operational requirements of the project. The nominee must be authorized and empowered to act on behalf of his/her organization. For continuity purposes, the person appointed must be available to serve throughout the development of the project.

SAMPLE B - IPT NOMINATION LETTER

MEMORANDUM FOR DIRECTOR, ACQUISITION MANAGEMENT & SUPPORT
DIRECTOR, COMMUNICATIONS & CUSTOMER SERVICE
DIRECTOR, HEALTH PROGRAM ANALYSIS & EVALUATION
DIRECTOR, INFORMATION MANAGEMENT, TECHNOLOGY & REENGINEERING
DIRECTOR, OPTIMIZATION & INTEGRATION
DIRECTOR, PROGRAM OPERATIONS
DIRECTOR, RESOURCE MANAGEMENT

SUBJECT: Appointment of Integrated Program Team Representative for Specialized Treatment Services/Centers of Excellence

Your support is requested in the development and implementation of deliverables for the Specialized Treatment Services/Centers of Excellence (STS/COE) Integrated Project Team (IPT). This team will develop a strategy for full implementation of mandatory criteria agreed upon by TRICARE Management Activity (TMA), the Services, and civilian experts for those facilities designated as "Centers of Excellence".

As the TRICARE Program Executive Officer, I have directed the formation of an IPT to be comprised of representatives from the Services and functional areas within the TMA. The IPT shall work collaboratively to address all issues regarding STS/COE.

I request that you appoint an individual from your Directorate to serve on this IPT. The individual should have the requisite authority and expertise to speak for your functional or operational area considering the project's scope. If you feel that a full time IPT representative from your Directorate is not necessary, please provide a point of contact to attend IPT meetings on an as needed basis. If you have any issues or concerns, which should be, addressed by the IPT, please contact the Program Manager, Col Geoffrey Rake. The IPT begins May, 2001, and expires upon completion of a comprehensive plan and DODI. The length of the IPT is estimated to extend approximately eighteen (18) months. It is desired for continuity purposes that the person appointed be able to serve throughout the development and implementation of the improved processes.

In your appointment memorandum, please use language that clearly describes the authority and limitations of authority that the appointed IPT member possesses. Please submit a copy of your appointment memorandum to me within two (2) weeks from the date of this memorandum. If you have any questions, please contact Col. Geoffrey Rake at (703) 681-0064, or Geoffrey.Rake@tma.osd.mil.

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

cc:
Ms. Cheryl Kaminska
Col Geoffrey Rake

2.5.2 Integrated Project Team Members' Roles and Responsibilities

- Assist the PM in developing strategies and project planning, as requested;
- Assist in establishing plans of action and appropriate milestones for particular issues requiring expertise;
- Propose tailored documents and milestone requirements;
- Review and provide timely input on documents and read-ahead materials;
- Assist in the resolution of project related issues in a timely manner;
- Assume the responsibility of informing key personnel within their organization of the project's issues, as well as applicable documents or portions of documents as they pertain to the project;
- Ensure alternate IPT members are briefed by the primary member and kept knowledgeable of the current status of the project.

2.5.3 Integrated Project Team Code of Conduct

In general, decisions made within the IPT are binding for its members. Although all members may not agree with each IPT decision, it is imperative that all IPT members ultimately defer to team consensus. Failure to comply may result in termination of IPT membership by the PM. The PM reserves the right, as the designated chair, to dismiss uncooperative members. Grounds for IPT dismissal include, but are not limited to:

- Failure to execute a Confidentiality Statement (CS), if needed **(See Section 2.5.4);**
- Excessive absenteeism at scheduled IPT meetings;
- Negatively contributing to overall IPT cohesion;
- Failure to perform assigned tasks in an efficient, timely manner.

Specifics in line with these guidelines will be established by individual PMs, with approval of the Director, PM&I or MDA, to fit the individual nature and disposition of their particular IPT. This code of IPT conduct will be disseminated to all IPT members at the inception of the IPT. Those identified as alternates by IPT members shall be briefed as to conduct expectations as well.

2.5.4 Confidentiality

Many of the PMO supported projects require the Project Manager and IPT to handle, disseminate or be party to the development or production of 'procurement sensitive' information. Information or documentation bearing this designation does so because inappropriate release may cause irreparable damage to government procurement or contracting action. An example would be

the inadvertent release of a confidential government cost estimate, or premature release of Request for Proposal (RFP) content that would provide an unauthorized recipient with an unfair advantage in drafting a proposal. Such release outside of government control to vendors can legally jeopardize and/or derail multi-million dollar procurements, and cost the government additional millions in legal mitigation costs in the event of a formal protest.

The Project Manager, through his/her operational interactions with TMA Contract Management Division, DSS-W, or the Office of General Counsel, shall be made aware of what information may fall into this category. Common sense and awareness of procurement rules generally dictates heightened sensitivity to the security and release of "government only" information of an official nature to only those with an "official need to know".

The following are suggestions to ensure confidentiality is not breached by the IPT.

- Physically safeguard sensitive information by storing it only in secure locations. Never take sensitive documents home.
- Conspicuously label documents as 'Procurement Sensitive' in the header and footer.
- Obtain signed Confidentiality Statements prior to the release of information **(See Business Plan in Appendix B for more detail.)**
- Make cautionary verbal statements to participants prior to the release of information. For example: "The information contained in this document (be specific) [or disclosed in this conversation] is considered by the Contracting Officer to be Procurement Sensitive. Release of this information outside of the government, or to those without an official need to know, is prohibited."
- Collect and destroy paper copies of the information at the conclusion of each meeting. Account for every page of every document.
- Ensure there is competent release authority and approval prior to any disclosure. In most cases, that authority will be the Project Manager or Contracting Officer
- Maintain a written record of what was released and when it was released. The signed confidentiality statement referenced above should accompany the written record or copy of what was released.
- At meetings attended by contractors, avoid conversations related to procurement matters.

Exercising discretion and good judgement will help avoid very serious problems. Do not put yourself in a situation where government confidential information is compromised through haste or carelessness. Know the boundaries and coordinate well with your Contracting Officer. If you are in doubt or have

questions regarding appropriate procedure, contact the Contracting Officer or legal counsel before disclosure.

2.5.5 External Participants

The PM approves all external participants of IPT meetings. Invitations may be extended in an effort to solicit further input on specific issues, seek clarification in significant areas as identified by the IPT, or when the primary or alternate is unavailable. As a rule, external participation is limited to an informational role at IPT meetings. Invited IPT participants shall not be privy to procurement sensitive information or be part of the decision making process. Moreover, it is the responsibility of the PM to secure the integrity of any procurement sensitive or otherwise privileged information.

An IPT member may request that a designated representative attend the meetings when the primary or alternate representative is unavailable. If the designated representative attends, the PM or WIPT chair must be notified. All meeting attendees who are not members of the IPT or WIPT must receive an invitation or prior approval from the PM.

Several policies and procedures apply when Managed Care Support Contractor (MCSC) participation is required at an IPT meeting. Prior to initiating a request for Government directed contractor travel, contact the Chief, Contract Administration Office, TMA/Aurora for guidance and assistance with contractor notification.

2.6 Identification of Working Integrated Project Teams

The Working Integrated Project Team (WIPT) is a short-term entity that works on a specific issue or problem to provide solutions or options to be decided upon by the IPT. This allows decision making at the lowest possible level.

While the IPT reviews progress with the project on a broad and strategic level, there will be instances when functional expertise for an identified issue will require more analysis by personnel who can devote the time necessary to develop a solution, or personnel who are functional experts in a field. WIPTs are working teams that are formed by the PM at the recommendation of the IPT to work on the resolution of a particular issue. The role of a WIPT is to provide specialized data and/or support in a defined area of expertise that may lie outside of the normal scope of activity for the IPT membership. There may be multiple WIPTs formed to support a project (e.g. Claims WIPT, a Pharmacy WIPT, and Enrollment WIPT, etc.). WIPTs are not required when an assigned tasking can be resolved within the Directorate responsible for the day-to-day operations surrounding the issue.

Depending on the specifics of the project and the tasks at hand, there are typically three ways to select the membership of a specific WIPT:

- Integrate with an existing group;
- Establish a group of subject matter experts; or
- Establish a cross-functional WIPT.

The PM has the flexibility to work the composition of the WIPT with IPT members. The WIPT Chair should be an IPT member selected by the IPT working group or the PM. Approval of members selected for participation must be obtained from the Directors of the organization to which they belong. Approval may be obtained either formally through an appointment letter, or informally through an e-mail request.

It is important to clearly define the expectations, responsibilities, boundaries and authority prescribed to each WIPT member. Following receipt of organizational approval, assignments of WIPT issues may be delegated as required. Upon satisfactory completion and submission of the assigned task, the WIPT Chair then formally requests to dismiss. After concurrence from the PM and IPT the WIPT may be closed.

2.7 Project Closeout

Each project must follow a completion process to formally closeout the project. This is the point where the IPT has completed its mission and the project is in the implementation phase. The PM must take the following steps with the assistance of the PM&I Office and the PC, to closeout the project.

2.7.1 Closeout Decision Paper to the PEO (See Sample C)

- Key Findings
- Accomplishments/successes
- Unresolved concerns
- Recommendations

2.7.2 Internal Audit of Documents

The PC will create a Final Closeout Binder for the Project Manager and the Director, PM&I Office. Binders will include all of the necessary documentation from the project.

2.7.3 Closeout Letters (See Sample D)

- Closeout letters will be sent to Project Manager(s) & Project Coordinator(s) from the PEO, thanking them for their participation in the IPT and informing them that the IPT is now formally closed.
- It is the responsibility of the PM to send closeout letters to the individual IPT members.

2.7.4 Completion Certificates

Completion Certificates will be sent to Project Manager(s) and Project Coordinator(s).

Please be aware that although the project is officially closed there may be activities that must continue to be monitored by the PM or staff.

SAMPLE C - CLOSE OUT DECISION PAPER

Newborn Enrollment Close Out Decision Paper

Submitted to: Maj Gen L. Randolph Jr.

August 2001

Program Identification:

Program Manager: Ms. Patricia Collins

Program Manager Phone: 703.681.0064 x3632

Program Manager Email Address: Patricia.Collins@tma.osd.mil

EXECUTIVE REPORT

Mission of the program:

The mission of the Newborn Enrollment Program was to resolve outstanding fiscal issues within the Revised Financing Regions 1, 2 and 5, as well as improve beneficiary education on newborn enrollment processes by way of marketing.

Key Findings:

- The TRICARE Management Activity (TMA) was receiving large bills for newborns in Revised Financing regions. Due to ambiguous contract language, newborns were being deemed enrolled to the closest Medical Treatment Facility (MTF), even if born in a network facility, and MTFs were being billed accordingly.
- The team realized that the main problems contributing to the lack of enrolling the newborn within 120 days included:
    1. Enrollment of the newborn is a two-step process; the newborn must be enrolled in the Defense Enrollment and Eligibility Reporting System (DEERS) prior to TRICARE.
    2. There are misconceptions about what documents are required for DEERS enrollment within the Services and locally. According to the Joint Instruction, all that is needed to enroll a newborn into DEERS is the *certificate of live birth* and the *DD1172*. Several sites require birth certificates and/or Social Security Numbers which are often not issued for months after birth; therefore further delaying the enrollment process.
    3. The requirement for in-person enrollment into DEERS at a Realtime Automated Personnel Identification System (RAPIDS) site has proven quite onerous for parents.
    4. Inadequate marketing and education efforts to newborn sponsors make it difficult for sponsors to know the correct processes.

Actions Taken/Accomplishments:

- TMA Resource Management (RM) has negotiated with the Revised Financing regions to solve the newborn claims issues.
- Members of the Defense Manpower Data Center (DMDC) are a part of the Team and have worked to clarify the Joint Instruction so that it is obvious that all that is needed to enroll a newborn is the DD1172 and the certificate of live birth. This correction to the JI-AFI36-3026 (I) is expected to be updated by fall of this year. In the meantime, DMDC has notified the RAPIDS training individuals that these documents are all that is needed.
- DMDC is making a mail-in and fax option an option for newborn enrollment.
- Working arduously with TMA, Communications & Customer Service (C&CS) to market this benefit by way of the Internet, fact sheets, interviews, press releases, etc.

- Contact has been made with the Lead Agent marketing representatives, as well as the Managed Care Support Contractors (MCSC) representatives so there is no duplication of efforts.
- Have briefed the Medical Personnel (MEDPERS) Shadow Group so that these issues are brought to top MEDPERS leadership; will continue to update the Shadow Group.

Unresolved Concerns:

- Current policy states that individuals can only be enrolled retroactively for 60 days; this logic has been programmed into the National Enrollment Database (NED). The 120-day timeframe for newborn enrollment obviously conflicts with this policy. One of the policies will have to be changed to support the other.

Recommendation:

- That the current Program Manager continues to work these issues and utilizes team members as necessary. The Program Manager is aware that she will no longer receive support from the Program Management & Integration.

Concur:

Permission to close out this program.

_____

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

SAMPLE D - IPT CLOSEOUT LETTER

MEMORANDUM FOR DIRECTOR, PROGRAM OPERATIONS DIRECTORATE

SUBJECT: Letter of Completion for the Claims Process Re-Engineering Program

The mission of this program was to identify problem areas in Claims Processing, to recommend a plan for cost-effective and efficient improvements in the system and to initiate approved changes.

The Re-Engineering Program was established in March 1999 and, through partnering with the Managed Care Support Contractors, achieved significant improvements in claims processing by eliminating root causes of re-work, increasing first-pass rates, removing barriers to electronic claims submission and auto-adjudication and decreasing deferrals. Additionally, an Executive and Operational Dashboard was developed to provide increased visibility to contractor performance statistics. All improvements were identified and implemented at no cost to Government. Some of the results observed to date include Aged Claims reduced from 30,000 in December '99 to 1,400 in October '00, elimination of over 100 pre-pay edits per region, reduction of claims adjustments, increased auto-adjudication rates and streamlining of the Audit Process, Performance Reporting and Coding & Pricing Update Processes.

The implementation phase started on November 1, 2000. Future plans include continued quarterly meetings with Managed Care Contractors and Lead Agent Office representatives, with the goal of identifying additional opportunities for improvement and implementing appropriate change.

Mr. Osoba's contributions as Program Manager throughout this Program were vital to reaching this milestone. His ability to establish a true partnering approach with all stakeholders was instrumental in achieving positive change in TRICARE claims processing. Although the implementation phase continues, the Claims Processing Program has successfully completed all milestones required to graduate from the Program Management Organization (PMO) program. I hope that the PMO guidelines and processes provided useful tools and structure for the program. I would appreciate any feedback you and/or Mr. Osoba may have to offer concerning the PMO.

I sincerely appreciate the time and expertise Mr. Osoba gave to help improve the provision of health care. There is still work to be done in the implementation phase, and I look forward to having him continue this effort.

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

Attachment: Certificate of Completion

cc:
Mr. Brian Rubin, Director, Program Operations Directorate
Ms. Cheryl Kaminska, Director, PM&I

SECTION **3**

Core Documents

- *Introduction*
- *Mission Needs Statement*
- *Milestone Chart*
- *Program Management Organization Business Plan*
- *Project Management Plan*
- *Other Supporting Documents*

3.1 Introduction

Core documents form the foundation and track the life cycle of the project. Their purpose is to clearly delineate project missions, goals, business rules, deliverables, timelines, recommendations and implementation plans. Upon closeout of a project, core documents become the reference tools for past project activity.

3.2 Mission Needs Statement

The Mission Needs Statement (MNS) is a formatted, non-solution specific statement containing operational capability needs. It is written in broad operational terms and describes required capabilities and constraints to be studied during the Concept Exploration and Definition Phase of the project. The premise of this document is that a successful plan starts with the end vision in mind; the mission or goal must be clearly identified and stated. **See Sample E.**

More concisely, the MNS addresses a 'mission need', i.e., a deficiency in current capabilities or an opportunity to provide new capabilities, reengineer existing capabilities, or to recalibrate an approach. It is developed through broad program management structures and processes. This document should be completed within ten (10) days of the IPT PMO Kick-off briefing.

3.3 Milestone Chart

The project milestone chart **(Sample F)** is a graphic view of the program's phases and those activities that need to occur within each phase. Each phase is completed with a decision point or milestone, at which time the IPT can move on to the next phase if successful. The milestone chart is a very important step in helping the PM determine the project schedule. Milestone charts will be included in briefs to the TMA leadership and submitted to the PEO each month. As of final publication of this User's Guide, all new projects will be using the new DoD 5000 format. Those projects that are already established have been "grandfathered", and will reflect the old format.

3.4 Program Management Organization Business Plan

The Program Management Organization (PMO) Business Plan **(Sample G)** enables the PM to identify the processes by which the project will be managed on a day-to-day basis. It lays out the roles and responsibilities of each of the organizations and individuals involved in the IPT process, from the MDA down to the PC. The PMO Business Plan presents the processes by which projects identified for program management and oversight shall be managed. It is provided as general guidance to assist the PM and IPT in managing the day-to-day operation of the specific program's management plan. This document is central to a successful project and requires thoughtful deliberation, meaningful

participation and careful documentation. This document should be drafted with the IPT Charter approximately ten (10) days after the first IPT meeting.

3.5 Project Management Plan

The Project Management Plan (PMP) provides a comprehensive project roadmap for how the project is going to be developed and run. It covers the project schedule, financial risks, and technical risks, as well as any measures or metrics that need to be established to measure the success or outcome of the project after implementation. (See **Sample H**.) It is meant to provide a starting point and provoke thought and discussion in the various areas that comprise a project. The document is the centerpiece of a project and summarizes the project. It is an iterative document, and can be updated as needed due to project change in direction or initiative. Generally, the PMP is done within sixty (60) days of the Business Plan.

Sample E - MISSION NEEDS STATEMENT

Mission Needs Statement
For
Centers of Excellence Implementation

This Mission Needs Statement (MNS) describes required operational capabilities (mission or purpose) for the Center of Excellence (COE) Implementation Program. This MNS identifies major program objectives that respond to the program's needs. The document defines the program's end result objectives, and will assist future decisions concerning the implementation of the program for future years to come.

This MNS contains the following sections:
Background
Statement of Need
Constraints Duration
Approval

A. BACKGROUND

The current Specialized Treatment Service (STS)/COE Program was initiated in 1995 in response to a Congressional requirement to assure and improve quality in the Military Health System (MHS). One of the nine initiatives, mandated by Congress, was the creation of centers of excellence within the MHS. The intent was to concentrate complex cases, those requiring the use of sophisticated skills and services, or the use of cross-disciplinary services in Medical Treatment Facilities (MTFs). Such services could be resources and evolved to provide the best, most efficient, highest quality care available anywhere, with the expectation that this would improve clinical outcomes. Thus, the STS designation was created. In a 1997 revision, 20 DRGs complicated, high-cost procedures were identified. Under the program, MTFs would not be allowed to perform procedures covered by these DRGs unless they were designated as an STS. Additionally, such status conveyed on the MTF extended Non-availability status (NAS) disapproval authority and imposed additional fiscal and administrative requirements. One year later, a second category, COE status, was created. This COE status was created at the request of several MTFs which did not desire extended NAS disapproval authority and did not wish to be burdened with the additional fiscal requirements, but did wish to continue doing the procedures under the restricted DRGs. The background policy memorandums from HA and the CFR describing the STS/COE program are included as attachments 1-4.

B. STATEMENT OF NEED

Currently, there are two national STSs, two multi-regional STSs, ten regional STSs and seven COEs. The facilities are listed in attachments 5 and 6. In

November 1998 a moratorium was placed on new STSs/COEs due to the following concerns:

- The extended NAS disapproval authority was a burden to patients and had negative impacts times on clinical continuity and quality of medical care.
- There was a lack of a validated process to compare quality or costs with civilian facilities.
- The STS/COE programs were ill defined without clear, standardized clinical criteria.
- There was poor compliance with annual report requirements that were meant to demonstrate the clinical quality and cost-effectiveness of this program.
- There were numerous concerns on the part of the beneficiaries, providers of the care and the legal experts in TMA/HA.

In response, standardized set of clinical quality of care criteria for the establishment of "Centers of Excellence" in ten DRG cluster areas were completed by panels of Tri-service DoD and civilian experts. These criteria, created at the direction of, and with funding by, the Healthcare Quality Initiatives Review Panel are the first in the country to establish broad, literature-based, expert- reviewed, standardized measures for the assessment, certification, designation and monitoring of Centers of Excellence.

The proposed plan that has been accepted by the Deputy Surgeon Generals and TMA is to work with a currently recognized, national, healthcare-accrediting organization to develop a Center of Excellence certification program. Such an organization (e.g., JCAHO), working with the MHS, would be responsible for the certification of candidate facilities, using the COE criteria and for the development and implementation of an assessment process created in collaboration with the MHS based initially on the COE criteria.

The STS/COE IPT composed of a representative group of senior health policy experts from the Services, OASD (HA) and TMA to develop a CONOPS and implementation plan for these criteria sets as the MHS standard. The IPT will formulate such DODIs as needed for program implementation. The IPT will work with the VA, HCFA, JCAHO, and other agencies, as appropriate, to further develop criteria sets and certification processes. This group will also be responsible for coordinating termination of the STS and associated NAS programs and new COE to include the final change to the Code of Federal Regulations (CFR) that outlines program changes.

C. CONSTRAINTS

The most immediate constraint is that no TMA funding for this program has been allocated. Funding is divided into two forms. The first is direct support of COE criteria set validation and changes, to include new criteria sets, if deemed necessary. The IPT will develop a budget to cover identified expenses. Second, no funding has been provided to support non-medical attendant travel, COE

program administrative or incentive funding. Negative BPAs are anticipated with STS termination for MTFs where use of NASs has been common. It is anticipated that STS termination can be accomplished without contract modifications.

A shared Service concern is that STS termination may affect Graduate Medical Education due to loss of patient volume as patients choose not to use MTFs. COE implementation will require extensive TMA and MTF marketing, as well as a sound communication plan to all the beneficiaries that will be affected by this change, to encourage their use of MTF as a matter of preference.

D. DURATION

The IPT is chartered initially for 18 months to ensure a comprehensive plan with a required DOD Directives is accomplished. All legal and contractual changes should be completed within this 18-month time frame. The transition program with evaluation of provisional COE and validation of the criteria sets, as proposed, will run through January 2004. In that case, the IPT will request re-chartering at an appropriate time to permit program completion.

APPROVAL

Col. Geoffrey Rake, USAF **Date**
Program Manager

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

SAMPLE F - MILESTONE CHART

TRICARE MANAGEMENT ACTIVITY

COE Milestone Chart

	Determination of Mission Need & Consideration of Technology Issues	Concept Exploration	Project Definition & Risk Reduction	Mature & Finalize Design/Process	Operations and Sustainment	
Tailored for TRICARE						
Tailored for **Centers of Excellence**	***Review alternatives for Programmatic Approach:*** ***•STS criteria ill-defined, unclear*** ***•poor compliance*** ***•NAS burdensome on patients and PCMs*** ***•New COE program with acceptable criteria desired.***	***Identify Requirements:*** *•Service representation and buy-in on COE concept* *Requirements Analysis* *•Budget evaluation* *•COE go vs.. no-go* *Strategy Development* *•CONOPS* *•Implementation Plan for 2-year new COE demo (COETP)*	***Develop Program Management Plan:*** *•PMP for new COE with 2- year transition period.* *•Identify WIPTS for criteria re-evaluation* *•Establish Certification process* *•Publish CFR* *•Finalize HA policy and contract mods to eliminate NAS and old STS.* *•DoDI Formulation*	***Begin and Evaluate COE transition demonstration:*** *• Plan Adjustment: 2 year transition; criteria evaluation and validation* *•Explore incentives for site participation* *•Evaluate data relative to clinical quality* *•Refine certification process*	***•Begin Full Program Execution of new COE program*** *•Integration into Funding Cycle for future FY's* *•Establish oversight entity to institutionalize & monitor COE Program* *•Close out IPT; continue COETP with new oversight entity*	***Full Implementation***

Start Date: 05/01

Milestone A
June '01
Approval of MNS and Charter

Milestone B
Aug '01
Approval of CONOPS and COETP Implementation Plan

Milestone C
Jan '02
End STS and implement new COETP

IPT Closure
Nov '02

Decision Points:

1. Approval of CONOPS; Jul 01
2. Approval of STS End / COE Implementation Plan; Aug 01

Current Issues:

- Timing and Funding to terminate STS/NAS (target Oct 01)
- Budget to terminate STS, 2-year COE transition
- Service acceptance of STS/COE CONOPS

Legend: Task Completed | On Going | Caution | Progress Stopped | Current Phase

SAMPLE G - PMO BUSINESS PLAN

PMO BUSINESS PLAN
FOR
THE ACCESS TO HEALTHCARE OVERSEAS PROGRAM

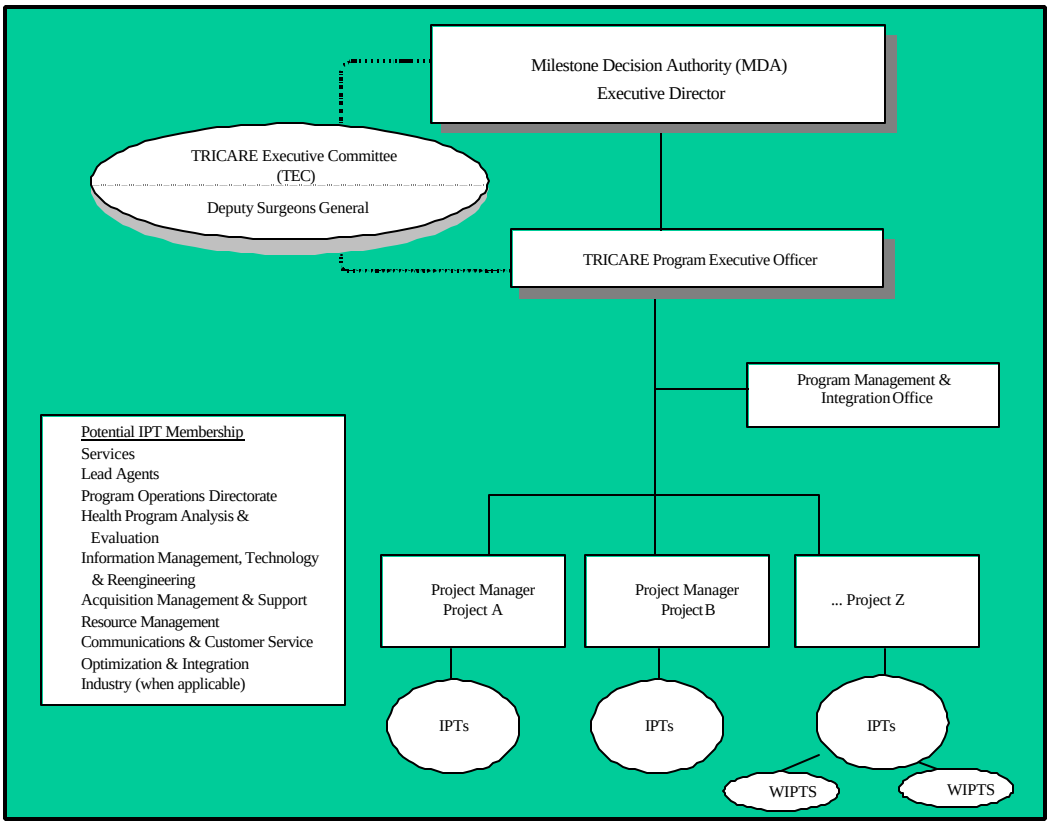
This PMO Business Plan presents the processes by which the Access to Healthcare Overseas Program shall be managed. This document's components include:

1. Participants' Roles and Responsibilities
2. Business Rules
   a. Participation
   b. Flow of Activity
   c. Communication Protocol
3. Relationship Between the Contract Management and Program Management Activities

I. ORGANIZATIONAL RESPONSIBILITIES AND RELATIONSHIPS

The chart below (Figure 1) depicts the decision-making hierarchy and the relationship between the TRICARE Program and the Projects. The roles and responsibilities of participants and organizations are detailed following the chart.

Figure 1
TRICARE Program Management Oversight



Once the overall direction and milestones are established by the Milestone Decision Authority (MDA), execution of the TRICARE Program operates as a "bottom up" activity – all execution decisions are made at the lowest appropriate level possible. Issues that cannot be resolved are elevated to the next level within the organization through completion. Ultimately, the MDA has the final decision authority for the TRICARE Program.

The Program roles and responsibilities are prescribed below pursuant to Figure 1.

Milestone Decision Authority (Executive Director, TMA)

The MDA (Executive Director, TMA) appoints and delegates responsibility to the TRICARE Program Executive Officer. The MDA also establishes the tailored

milestone decision points for the TRICARE Program and all of its elements. At each milestone or program review, the MDA determines that the project being reviewed is progressing satisfactorily. Favorable milestone decisions permit the program to proceed.

TRICARE Executive Committee/Deputy Surgeons General

The TRICARE Executive Committee (TEC) and the Deputy Surgeons General serve as advisory committees at the request of the TRICARE Program Executive Officer or the MDA. The TEC will also serve as the liaison between the Services and the TMA on direct care issues.

TRICARE Program Executive Officer (Chief Operating Officer, COO, TMA)

The TRICARE Program Executive Officer (PEO) will oversee the execution of all TRICARE related actions. The PEO is responsible for planning, directing and controlling the TRICARE Program and all of its elements. The TRICARE PEO determines a program's inclusion in the PMO and assigns Program Managers as necessary.

Program Management & Integration Office Director

The Director, Program Management and Integration (PM&I) Office, oversees the design, implementation and maintenance of the Program Management Organization. The PM&I Office director works with the TRICARE PEO and all Program Managers providing program and acquisition management support on a continual basis.

Acquisition Management Office – Washington Director

The Director, Acquisition Management Office – Washington (AMO_W), provides support to the PEO and Director of PM&I Office in overseeing the design, implementation, and maintenance of the PMO. The Director will work with the PMs providing program acquisition management support as needed.

Program Management &Integration Project Coordinator

The Project Coordinator acts as a representative of the PM&I Office and provides technical and administrative support to the PM and IPT on a daily basis. This support will include overall integration, document preparation, master schedule maintenance, and activity tracking. The PC also functions as the main point of contact for coordination of information or issues that arise during the course of the program. Project PCs meet regularly with the PM&I Director and AMO-W Director to provide status on their programs.

Program Manager (PM)

The Program Manager is assigned to TRICARE related activities known as programs. The Program Manager is accountable and responsible for the day-to-day activities and for ensuring that the program progresses through the tailored

management model. The Program Manager reports status and progress to the Director, PM&I Office. The Program Manager is responsible for the successful completion of his or her defined requirement(s). Program Managers and Integrated Program Teams (IPTs) will receive their authority and responsibilities through memoranda signed by the TRICARE PEO.

Integrated Program Teams (IPTs)

On an as-needed basis, the organization will form IPTs comprised of members from the various departments of TMA, the Services, and other applicable groups. The IPT composition will be based upon the requirements for the specific program. The IPT members are authorized to speak on behalf of, and task others within their organization. For continuity purposes, it is desired that the IPT members serve throughout the defined period.

Working Integrated Program Teams (WIPTs)

WIPTs are working teams represented by cross-functional disciplines. IPTs form a WIPT to analyze a specific issue and recommend potential solutions when input from more than one organization or functional discipline is needed. The director or head of each agency or operation will typically appoint WIPT members. The PM will appoint WIPT Chairs. There may be many WIPTs formed for a single program to address diverse issues.

To facilitate the goal of developing a single concept of operations for medical/dental care overseas, the following WIPTs will be formed. As the program evolves, additional WIPTs may be comprised as needed.

Remote Healthcare WIPT: The WIPT will examine obstacles to delivering healthcare at remote sites, and will make recommendations to increase its availability to both residents and visiting beneficiaries.

Claims Processing WIPT: The WIPT will assess claims processing procedures for care received outside the United States and make recommendations to standardize and streamline procedures. The WIPT will also examine and make recommendations concerning varying regional approaches to Third Party Liability claims.

Access to Care WIPT: The WIPT will assess OCONUS MTFs current capacities and assess the ability to absorb additional beneficiaries, to include examining the possibility of extending TRICARE Prime to retirees residing overseas.

Dental Care WIPT: The WIPT will examine the current structure of the program and availability of services used to deliver the benefit, methods for claims processing, state of dental services delivery to active duty service members and their families, and make recommendations on improving access and quality of care.

II. BUSINESS RULES

The following rules guide the program participants through the day-to-day management and operation involving the Access to Healthcare Overseas Program.

A. Participation

All Government and contractor participants must execute a Confidentiality Statement (CS) prior to receiving any program management sensitive information. Integrated Program Team (IPT) members not privy to program management sensitive information are not required to sign the document. They must, however, receive a CS and acknowledge that they understand and will comply with the stated requirements. All new participants will be directed to the Program Manager (PM) who will issue the CS. The original is kept by the PM, who will maintain the list of authorized participants.

Prior to all meetings, attendees will be screened against the list of authorized participants. In the event a participant does not abide by the stated requirements, the PM may remove that individual from this program.

Depending on the scope of the program, a Deputy Program Manager may be assigned to provide additional management support. In this instance, a manager may delegate confidentiality documentation duties to his/her Deputy Program Manager.

Attendance at IPT meetings is normally limited to IPT members and those directly invited by the PM. Attendance at Working Integrated Program Team (WIPT) meetings is limited to WIPT members and direct invitations from the WIPT chair.

There may be meetings with participation from other areas within the TRICARE Management Activity; core PM&I staff that may consist of Government, military, and/or contractors; staff from the Surgeons General offices, or other designated offices. The PM may invite the individual(s) to attend specific meetings. The PM will be responsible for ensuring that invited personnel are instructed on the TRICARE PMO business rules regarding program sensitive information, (if applicable). IPT members may also recommend to the PM that an individual or group attend a meeting(s) to assist in issue resolution.

IPT members should identify an individual from their workspace to serve as an alternate IPT member for those meetings they cannot attend. While alternate IPT members will not be required to attend or participate in regularly scheduled IPT meetings and tasking, they will be responsible for compliance with the rules identified in this Business Plan.

In the event a discussion at an IPT meeting results in a vote for a particular issue, alternate IPT members may provide input but not serve as voting members.

B. Flow of Information

All items (contracts requirements, documents, questions, comments, information requests and issues) concerning the various areas that comprise a specific program's management plan or regarding the status of the program will be initially directed to the PM unless otherwise delegated by the PM to a designated IPT member. The PM will keep a log of items, with the assistance of their program coordinator, to include: source, data received, data resolved, action officer (either an individual, IPT, or WIPT), status and disposition. The PM will not release any information regarding the Access to Healthcare Overseas Program to unauthorized participants unless a need to know exists.

C. Communication Protocol (for procurement sensitive programs only)

Email communication within the Health Affairs/TRICARE Management Activity (HA/TMA) Network is secure for sensitive information and authorized provided:

- **The email has "Procurement Sensitive" printed at the top and bottom of the email in legible print**
- **All recipients have a need to know and have agreed to the terms of the CS**
- **No recipient is located outside of the TMA Local Area Network (LAN)**

Documents and files sent to authorized participants outside of the HA/TMA network must be accomplished using traditional safeguarding measures such as approved Courier Services (i.e., Federal Express) unless a secure email communication channel has by approved by the PM.

Any questions regarding these procedures should be forwarded to the PM who will resolve the issue.

III. RELATIONSHIP BETWEEN PM&I OFFICE AND PROGRAM MANAGEMENT ACTIVITIES

Program Management & Integration activities will be coordinated through the PM&I Office to ensure the successful completion of all initiatives identified for management and oversight by the PMO. The objectives of the collaboration are to eliminate duplication of effort between the multiple activities, and integrate Program Management programs and projects and to secure the efficient production of identified deliverables. All activities will use a teamwork approach to identify issues, resolve those issues, and keep the deliverables on a schedule to meet established milestones.

The PM&I Office and selected PMs will work closely to coordinate activities and share information. A collaborative approach will be taken to meet identified milestones and resolve issues critical to the overall PMO success.

IV. APPROVAL

Program Manager	***Date***
TRICARE Deputy Executive Director	***Date***

SAMPLE H - PROJECT MANAGEMENT PLAN

SELF REPORTING TOOLS

PROGRAM MANAGEMENT PLAN

REVISED DRAFT

January 2001

Purpose and Overview

Revisions to this document are being made to reflect the new direction of the Self-Reporting Tools Program. The initial focus of this program, as depicted in the original version of this document, was to fix the paper-based HEAR v1 that is currently being used throughout the MHS. The new focus of this program moves beyond the paper-based HEAR and is looking at creating an integrated and modular approach for the collection, storage, study and use of all MHS self-reported information by use of an automated HEAR tool (v2.x) accessible by PC or the web. The TMA Directors and the DSGs approved this new program direction in November 2000. The efforts of this IPT aim to eliminate duplication and waste associated with the use of multiple self-reporting tools (SRT) across the MHS and to create a strategy to support MHS population health objectives and Healthy People 2010 population health programs.

Background

The Health Enrollment Assessment Review (HEAR) v1.0 was developed in response to a request from TRICARE Region 6 to assess the patient population in that region. The Office of Prevention and Health Services Assessment (OPHSA) developed the self-administered, 82-item questionnaire. ASD (HA) Policy Memorandum of October 1996 established the HEAR 1.0 survey as the DoD designated instrument for health assessment and directs all Lead Agents to implement the HEAR Program. In addition, the Put Prevention Into Practice (PPIP) campaign developed by the U.S. Public Health Service's Office for Disease Prevention and Health Promotion requires that appropriate and comprehensive prevention services be provided to all patients based on their age, sex and risk factors. ASD (HA) PPIP Policy requires that all TRICARE prime enrollees participate in the HEAR Program by April 1999.

The current DoD standard self-reported health information tool is the paper-based HEAR 1.3, which is the Y2K-compliant version of HEAR v1.0. The HEAR was designed to establish baseline health status, identify enrollees in need of preventive services, assist with PCM assignment, identify health risk behaviors, predict resource utilization, and provide the PCM and medical managers with reports and tools to assist in health care management. The HEAR has failed to live up to its expectations due to inconsistencies in contractor administration, poor beneficiary compliance, lack of identified PCMs to receive the reports, and confusion about its purpose. The current automated version of the HEAR (v2.x) is a considerable improvement over the paper-based version, but it is time consuming to complete. Currently, the automated HEAR 2.x can only be completed using PHCA, and cannot be completely fielded without CHCS II. Additionally, as many as 83 other SRTs and data collection systems are in use across the MHS. These SRTs are often service specific, duplicative, and poorly coordinated. Much of the information gathered in these SRTs is available through the current HEAR. There is no coordinated MHS strategy to standardize

or share this data. Further, there is no central repository to enable longitudinal collection, study, or utilization of this data.

Objective

The overall objective of this Program is to effectively deploy a standardized SRT throughout the MHS that meet the defined needs of the customers.

As defined by the Assistant Secretary of Defense for Health Affairs [ASD (HA)], the mission of the Health Enrollment Assessment Review (HEAR) is: to provide medical and behavioral information on active duty personnel and TRICARE Prime beneficiaries to primary care managers, MTF commanders, resource managers, TRICARE contractors, line commanders, lead agents, military service departments and the Department of Defense. This use of SRTs is central to the MHS strategy for Force Health Protection (FHP) and the TRICARE program through:

(1) Establishing baseline and ongoing health status of our active duty members to monitor operational fitness;

(2) Identifying TRICARE Prime enrollees requiring preventive health care services, assigning patients to a primary care level based on complexity of care required; classifying patients according to predicted level of resource utilization; and identifying patients with high risk behaviors who can benefit from intervention.

Scope

The SRT/HEAR IPT has joined forces with IMT&R to support the objectives of the Health Care Quality Information and Technology Enhancement Authorization Act – Section 723. We are now collaborating with an independent research group from Yale university to evaluate the HEAR and the pre and post-deployment questionnaires for validity, reliability, and efficacy. Problem Knowledge Couplers (PKC) will be used as the interface to move data from these questionnaires to CHCS II. HEAR and pre and post-deployment modules have already been created. These modules function well in a stand-alone mode, can easily be web-enabled for remote usage, and preserve data for incorporation into CHCS II. A demonstration project is planned for rollout with CHCS II in 2001. The Yale group anticipates a long-term commitment to this initiative and is currently researching other MHS SRTs for incorporation into an enterprise-wide SRT strategy. Their commitment includes research of longitudinal self-reported information to assess health care outcomes and support of MHS population health objectives.

The SRT IPT seeks to accomplish the following objectives:

- Consolidate all existing MHS SRTs into an enterprise-level self-reported information management strategy such that questions are not repeated and required data can be easily extracted from CHCS II through standard reports.
- Insure questions are relevant, useful, valid, and provide necessary information for patients, providers, MHS managers, and warfighters.
- Rather than a single lengthy questionnaire, use dynamic modules that are timed to age, life cycle events, or triggered by career events (deployment, occupational exposure, retirement, etc). These modules will be subsets of the full, comprehensive tool.
- Tailor modules to populations such as adolescents, Medicare eligible, reservists, high-risk military occupations. Enable continuation into retirement and VA health care.
- Enable data extraction to support activities such as PCM assignment and resource management.
- Facilitate intervention strategies to improve individual and MHS population health.
- Create a cell in the MHS Optimization and Population Health Support Center (MHS OPHSC) for ongoing support and improvement of SRTs, study of self-reported data, and feedback to MTFs, Commanders, Lead Agents, and MHS leaders on health status of our service members and TRICARE prime enrollees. Create an MHS/TMA hub but use regional population health offices and service preventive health activities as component parts of a virtual MHS support center.
- Establish a clinical data repository (CDR) and Master data repository (MDR) to collect self-reported information and marry it with clinical information to add to the patients medical record.

Program Strategy

The major activities of the Program will be implemented in four phases:

Pre-Phase Re-establishment of Mission Need: Move away from v 1.3 & establish another tool

Phase 0 Concept Exploration: Develop Alternative to HEAR 1.3
Roll out HEAR 2.x as stand-alone
Web-enable HEAR
Modules for smaller HEAR survey for readiness (PKC technology)
Coordinate with Yale research group on assessment of MHS tools
Examine CDR and MDR possibilities
Explore MHS OPHSC concept
Approval of Approach by PEO/MDA, DSGs - **MS I 11/00**

Phase I Program Definition and Risk Reduction: Develop Plan
Develop Functional Requirements
Develop Concept of Operations

Develop HA Interim Policy
Integrate Yale analysis and recommendations
Develop MHS OPHSC framework
Define requirements for modular HEAR(s)
Approval of Plan by PEO/MDA, DSGs- **MS II 4/01**

Phase II Mature and Finalize Design & Processes (Implementation Plan)
Develop Implementation Guidelines
Field Interim Guidance Policy
IGCE and Change Order process
MHS OPHSC business process formalization
Marketing and Training for HEAR 2.x
Approval for implementation by PEO/MDA, DSGs - **MS III 10/01**

Phase III Deployment and Operational Support
Establish SRT oversight in MHS OPHSC
Phased roll-out of HEAR 2.x
Transition out - **MS IV 12/01 - 1/02**

The Program will proceed through all of the phases ending with ongoing support for the finalized product(s) within the TMA. The basic tenets of Program Management as proscribed in DoD 5000 and Optimization and Integration will be adhered to.

Management Approach

The management approach for the Self-Reporting Tools Program will follow a tailored version of the management model detailed in DoD 5000.2R, Mandatory Procedures for Major Defense Acquisition Programs (MDAPs) and Major Automated Information System (MAIS) Acquisition Programs. The DoD 5000.2-R management process is structured in logical phases separated by major decision points called milestones. The process begins with the identification of broadly stated mission needs and translates those needs into a stable, affordable, well-managed program.

At program initiation and after approval the mission need, the Program Manager (PM) will propose for consideration to the PEO/MDA: the appropriate milestones, the level of decision-making for each milestone, and the documentation for each. Changes and recommendations will be coordinated among the PEO/MDA, the Director of PM&I, and the Program Manager and incorporated into the Program Management Plan (PMP). This plan will be submitted to the PEO/MDA for final approval.

In addition to this structured, yet tailored approach, key tenets of the DoD 5000.2-R acquisition management model will be used to integrate essential cross-functional disciplines to optimize program decisions. The cross-functional

IPT (stakeholders) will execute the program. When possible, the IPT will use a consensus decision-making process.

Migration Strategy

A transition plan will be developed as technologies and requirements are identified and refined to meet the objectives of this Program. Current policies and procedures in fleet, operational, direct care and contract settings may be affected, and will be taken into consideration when establishing the functional requirements for the automated HEAR. Existing technology systems will be examined for their ability to meet requirements. Oversight for the final product will transition from this IPT to the newly established MHS Population Health Support Office.

Program Integration

The Program Management and Integration Directorate is responsible for compiling and analyzing information from all of the TRICARE Programs. PM&I will build and maintain systems that will store all documents, schedules and data for all programs, enabling the Program Manager and Director, PM&I to:

- Identify opportunities for program collaboration when desirable

- Identify program's impacts on other TRICARE programs.

- Identify program's impacts on the overall TRICARE Program.

THE PROGRAM MANAGER REPORTS REGULARLY TO THE DIRECTOR, PM&I, AND PEO/MDA ON PROGRAM INTER-RELATIONSHIPS, SCHEDULE CONFLICTS, PROGRAM STATUS, ETC. WHEN NECESSARY, THE PM WILL INTERACT WITH PMS OF OTHER RELATED PROGRAMS TO ATTAIN CONGRUENCY OF EFFORT AND AVOID DUPLICITY.

IT IS ANTICIPATED THAT INTEGRATION WILL BE REQUIRED WITH THE CLINICAL INFORMATION TECHNOLOGY PROGRAM OFFICE (CITPO) TO ESTABLISH A CDR FOR SELF-REPORTED INFORMATION, AND IN THE FACILITATION OF FUNCTIONAL REQUIREMENTS AND DEPLOYMENT OF THE STAND-ALONE AUTOMATED HEAR. THIS IPT WILL ALSO WORK WITH THE EXECUTIVE INFORMATION DATA SYSTEMS (EIDS) OFFICE TO ESTABLISH FUNCTIONALITY WITH THE MDR TO RETAIN STATIC CLINICAL INFORMATION FOR USE BY VARIOUS AUTHORIZED ENTITIES THROUGHOUT THE MHS. ULTIMATELY, CHCS II WILL NEED TO BE FIELDED TO MAKE THESE FUNCTIONS FULLY OPERATIONAL.

Data Standards

Health Insurance Portability Performance Act (HIPPA) standards may apply to SRTs because they link a name to patient data. If the current proposed standard is adopted by Congress, this will mean when data is transmitted over a Wide Area Network or the web, it must be encrypted and must have a digital signature attached at both sending and receiving ends. Proposed standards after 2000 will be Advanced Encryption Standard (AES).

Consideration must be made for potential security classification of aggregated reports relating to a specific Unit Identification Code (UIC) or other readiness data. Data classification standards (different than HIPPA) must be adhered to.

SRTs have the potential to impact a wide variety of MHS wide and service specific systems that must be evaluated for impact including CHCS, CHCSII, PHCA, DEERS, CEIA, SAMS, HRA, etc.

Performance Metrics

Performance measures to track the success of this Program will be established. Vital to the success of the Program is incorporating metrics on the MHS Report Card. Performance measures will be directly tied to the objectives and requirements of the program and will be designed to evaluate program effectiveness, address appropriate organizational levels, identify trends and address or incorporate civilian benchmarks. Other issues include protection of respondents' privacy and assurance that regulatory guidance regarding implementation of surveys is met. These performance parameters will be developed and monitored by the SRT oversight entity of the MHS Population Health Support Office.

Resource Requirements

Funding will be required for the roll-out of the automated HEAR and its modular components in a standalone format. Development of the automated HEAR and the modules is already funded, and largely complete. Upon review of the functional requirements, IMT&R may decide to fund this effort and task it through one of the functional business areas within TMA, such as CITPO. If not, funding will need to be sought elsewhere and this effort will need to be contracted out via D/SIDDOMS or a similar contracting vehicle. Additional resources will also need to be sought for the MTFs to support the administration of the automated HEAR, i.e. personnel, computers, etc.

Risk Assessment/Technical Risk

HEAR 2.x will initially be deployed as a stand-alone system, thus it will not require CHCS II to operate. However, until CHCS II is fielded, connectivity to a CDR and the MDR will be needed to store the HEAR data for population health assessment and as a reference for a person's medical record.

Patient confidentiality is the key risk in the use of the HEAR or any other SRT. A TMA-approved Privacy Act Statement for HEAR 2.x will need to be strictly adhered to, particularly for web enablement. The developers of the HEAR software will need to work in concert with TMA to come to a consensus on an acceptable statement to use for all versions of the HEAR software that are released.

Programmatic Risk

The current course of this program has been briefed and approved by IMT&R, the TMA Directors, and The Deputy Surgeons General. However, these efforts are running in collaboration with a study being conducted by Yale University of all MHS tools currently being used. The recommendations made as a result of this study will need to be incorporated into plans to implement a unified self-reporting tool throughout the MHS. Any recommendations made that run contrary to the current roll-out plan could delay progress in accomplishing the mission of correcting the current problems associated with the paper-based HEAR.

Cost Risk

Resources need to be identified for Program Management at the TMA level. This includes personnel and funding resources to support activities under the control of the PM and the subsequent risk mitigation efforts. Resources for ongoing oversight of the HEAR program after the IPT has completed its charter will also need to be adequately assessed.
Contract modifications will be needed to relieve the MCSCs of their current obligation to collect and process the paper-based HEAR 1.3. Monies re-cooped from these contracts will result in savings to the government, but additional costs will need to be considered for the additional resources needed for the MTFs.

Consideration must also be made for costs tied to other SRTs currently in use or development that may be discontinued as a result of SRT integration or the recommendations made by the Yale Research Group upon completion of their study.
Schedule Risk:

Schedule risk will be identified with schedule slippage within the program life cycle and in related programs. Mitigation strategies including schedule metrics,

use of incremental development and delivery activities, and application of realistic estimation processes for planning activity program will be utilized.

Approvals

IPT Program Manager	**Date**
TRICARE PEO/MDA	**Date**

3.6 Other Supporting Documents

Below are documents that may be used in addition to the core documents. The determination of need for these documents is at the discretion of the PM.

3.6.1 Integrated Project Team Charter

The IPT Charter is a memorandum signed by the TRICARE PEO that essentially indoctrinates the IPT. It briefly summarizes the purpose and scope of the project and lists the organizations represented in its membership. Chartering an IPT formalizes the authority to make decisions on behalf of TMA leadership, provides a means of decision making and institutes an approval process.

3.6.2 Primavera v3 Schedule

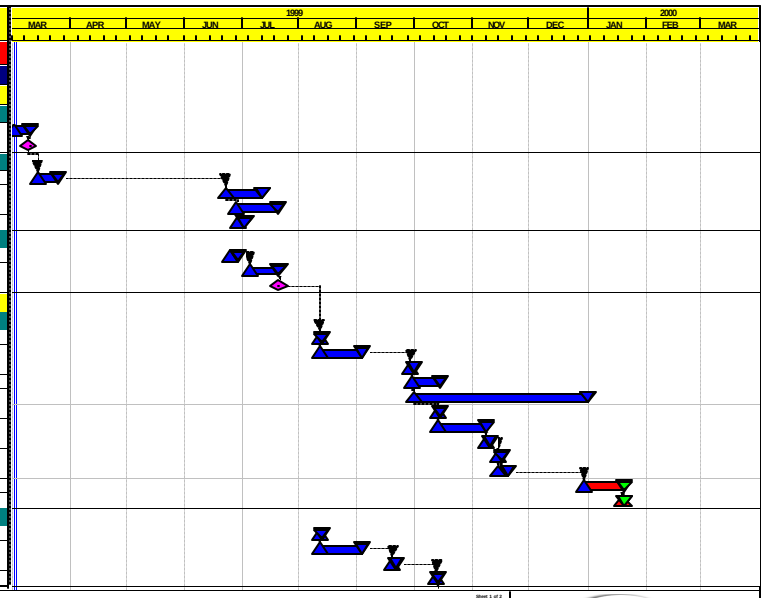
The Primavera v3 (P3) scheduling application is the DoD standard for scheduling phases, taskers and milestones of a project. Each project is typically printed in a Gantt chart format (Sample I) which will depict the current status of the project and the repercussions of any subsequent delays. Input from the functional proponents is vital in developing the schedule to ensure adequate time intervals are established. Once the schedule baseline is set, the P3 tool is primarily for the use of the PM and PC to assist in the management of the project.

SAMPLE I - PRIMAVERA v3 (P3) SCHEDULING CHART

TRICARE MANAGEMENT ACTIVITY

Standard Program Schedule Format

Activity Description	Early Start	Early Finish
TRICARE Program Management Support Ofc		
Enrollment Integration		
Pre-Phase: Mission Need Determination		
Establish INTEGRATION NEED		
Decision to form IPT	03MAR99A	10MAR99A
Program Kick-Off	10MAR99A	
Establish PROGRAM STRUCTURE		
PM Appointment Letter	15MAR99A	25MAR99A
IPT Appointments	23JUN99A	12JUL99A
IPT Charter	29JUN99A	19JUL99A
IPT Milestone Chart	30JUN99A	02JUL99A
Develop MISSION NEED Statement		
Draft MNS	25JUN99A	29JUN99A
Final MNS	06JUL99A	20JUL99A
Milestone 0 - Approval of Mission Need Statement		20JUL99A
Phase 0 & 1: Concept Exploration & Dev of Plan		
Develop STANDARD ACTIVE DUTY ENRLLMT/MAT Policy		
W-IPT topic established (1st IPT Meeting)	12AUG99A	12AUG99A
W-IPT members selected (2nd IPT Meeting)	12AUG99A	02SEP99A
Requirements Identification (San Antonio W-IPT)	29SEP99A	30SEP99A
Issues/Requirements Matrix Developed	30SEP99A	14OCT99A
Standardized Enrollmt Form: Revisn/Complet/Appr	01OCT99A	31DEC99A
Update on Requirements (3rd IPT Meeting)	14OCT99A	14OCT99A
Review Requirements Course of Action	14OCT99A	08NOV99A
Present W-IPT Status (4th IPT Meeting)	09NOV99A	09NOV99A
Timeline Integration Meeting w/LIM&PEDE IPT reps	15NOV99A	15NOV99A
Draft MCSC In-Processing Role Contract Language	15NOV99A	19NOV99A
Develop Enrollmt Standardizatn Implementatn Plan	30DEC99A	20JAN00
Issue Decision Paper Wrap-Up & Review (5th IPT)	20JAN00	20JAN00
Develop ENROLLMENT FEE MONTHLY PAYMENT Reqs		
Establish W-IPT Topic (1st IPT Meeting)	12AUG99A	12AUG99A
Select W-IPT Members (2nd IPT Meeting)	12AUG99A	02SEP99A
Identify Requirement Elements (1st W-IPT)	20SEP99A	20SEP99A
Review Requirements Course of Action(2nd W-IPT)	13OCT99A	13OCT99A



Project Start 03MAR99
Project Finish
Data Date 03MAR99
Run Date 09FEB00

Early Bar
Float Bar
Progress Bar
Critical Activity

TRICARE Management Activity
Enrollment Integration Project Sched
Program Management Layout

Program Management & Integration

Page 1

SECTION **4**

Reporting Requirements

- *Initial Brief to Program Executive Officer*
- *Program Management Organization Kick-off Meeting*
- *Concept Approval Briefing*
- *Integrated Project Team Review Briefing*
- *Milestone Approval Briefing*

4.1 Initial Brief to Program Executive Officer

The PEO and Director, PM&I Office will meet with the newly appointed PM to discuss the project selected for program management. This meeting provides an opportunity to discuss project issues such as IPT membership, project scope, project funding, technological alternatives and possible outcomes of the program management process.

4.2 Program Management Organization Kick-off Meeting

The Director of PM&I Office and the PC will meet with the newly appointed PM to discuss the PMO process. This meeting will provide the PM with an understanding of the purpose of PMO, the tailoring of DoD 5000 to TRICARE and the roles and responsibilities of the Director of PM&I Office, PM and PC. Funding availability and constraints, IPT membership, structure and responsibility, and the reporting process will also be reviewed.

The PM&I Office Director will provide an additional orientation for the PM that includes:

- Selecting IPT members and requesting appointments to the IPT;
- Initiating project implementation strategies;
- Reviewing requirements for the Mission Needs Statement and Project Management Plan;
- Reviewing project priorities and kicking off the project;
- Identifying functional requirements, budgetary requirements and data quality elements as applicable.

4.3 Concept Approval Briefing

Once the PM has decided on a course of action and established a plan for the Mission Needs Statement and a plan to initiate the program management process, a meeting will be scheduled with the PEO/TMA Directors six to eight weeks after the project "kick-off." This brief is to review a concept of operation that includes project definition, goals and progress. Suggested items are:

- Mission Needs Statement (project mission)
- Milestone Chart (timeline)
- IPT composition
- Funding requirements
- Information Management/Information Technology Requirements
- Project specific concerns

4.4 Integrated Project Team Review Briefing

The PM is required to periodically brief the status of the IPT to the PEO, the TMA Directors and Service representatives. The purpose of these briefings is to update all the stakeholders on the status of the project. The brief should be identified as informational or as a request for a decision. Briefing slides are due to the PM&I Office one week prior to the actual brief for advance distribution. The PM must have an IPT Review brief prior to briefing the DSGs. Topics that should be discussed are:

- Progress based on mission
- Timeline
- Funding requirements
- Roadblocks and/or issues
- Next steps and decision points

These briefings are set up by the PM&I Office. The PM&I Office will also give the PM guidelines on the standard briefing format.

4.5 Milestone Approval Briefing

When an IPT has approached a milestone, a meeting will be scheduled for the PM to brief the progress made with the project. Milestone briefings are presented to the PEO and DSGs. This briefing must be clearly identified as a milestone brief, state accomplishments in the current phase and request permission to move to the next phase. Decision points must also be highlighted during the brief and presented for additional direction, approval or disapproval. The PM should provide the necessary document(s) to be signed as approval to go to the next phase or step. **(See Section 3 on Milestone Chart)**

SECTION **5**

Change Management

- *Definition of Change Management*
- *Roles & Responsibilities*
- *Process*
- *Planning, Programming & Budgeting System and Project Funding*

5.1 Definition of Change Management

Change Management (CM) is the process by which changes are made to the TRICARE baseline. It begins with a change request proposal and ends when the implemented change becomes part of "normal business". These changes include new services, expansion of the current benefit, optimization efforts and administrative updates. Initiatives can be driven by Congressional legislation, professional/community standards of care, or contractual obligations. The primary navigator of the CM process is the PM. He/She must ensure the project successfully progresses through the TRICARE Program Management Organization model and its inherent milestone decisions. The Program Management & Integration Office facilitates the TRICARE change management process. Frequently Asked Questions (FAQs) about Change Management can be found in **Appendix D.**

5.2 Roles and Responsibilities

Below are roles and responsibilities of various individuals and groups in relation to the change management process.

Change Management Board (CMB)

The TRICARE **Change Management Board (CMB)** is chaired by the TMA Deputy Executive Director/PEO and serves as the executive level board responsible for approving new changes. The Services' Deputy Surgeons General and the Joint Chief Staff (JCS) J-4 Medical Officer are on the CMB. The CMB acts as the Milestone Decision Authority (MDA) for the TRICARE Program. The scope of responsibility includes the continuous monitoring of TRICARE changes, and the review, approval and prioritization of TRICARE benefit changes that represent a policy shift or fiscal impact.

Program Executive Officer (PEO)

The TRICARE **Program Executive Officer (PEO)** is ultimately responsible for implementation of all TRICARE projects and related managed care support contracts (MCSCs). He/she approves projects for concept exploration and chairs the Change Management Board.

Health Services Delivery Steering Group (HSDSG)

The TRICARE **Health Services Delivery Steering Group (HSDSG)** is comprised of O-6 level representatives from each Service who work with the TRICARE and direct healthcare projects in the military treatment facilities

(MTFs). On a semi-annual basis, the group prioritizes newly developed project changes and requirements for implementation and makes recommendations to the Change Management Board.

Resource Management Steering Committee (RMSC)

The TRICARE **Resource Management Steering Committee (RMSC)** membership includes Senior Comptrollers from each Service component served by the DHP. The TMA Deputy Director for Resource Management chairs the committee. In coordination with the HSDSG, the RMSC makes project funding recommendations. The group also reviews cost estimates submitted with change packages.

Regional Management Team (RMT)

The TRICARE **Regional Management Team (RMT)** consists of technical and contracting personnel from DoD/Regional Operations, TMA/Acquisition Management & Support Directorate, the Lead Agent Staff, and the MCSCs. The team is responsible for implementing project changes as approved by the CMB and the TRICARE PEO.

Program Management & Integration (PM&I) Office

The TRICARE **Program Management & Integration (PM&I) Office** facilitates the TRICARE change management process. It coordinates support staff for Project Managers, maintains a master status listing of all projects and coordinates all executive level briefings related to project updates. The PM&I Office is the primary liaison between the PEO and Project Managers.

Project Manager (PM)

The TRICARE **Project Manager (PM)** is accountable and responsible for the day-to-day activities of his/her project and for ensuring the project progresses through the change management process. Required tasks include the completion of mandatory and discretionary documents, certification of cost estimates, coordination of funding requests and the appropriate briefing of decision making bodies. He/She is required to brief various entities for approval and remains the primary contact for project status through project implementation.

Change Cycle Manager

The TRICARE **Change Cycle Manager** implements the semi-annual group of changes approved by the CMB. He/She is assigned to the Program Operations

Directorate (POD) and works in close coordination with the PM. The Change Cycle Manager is lead facilitator for the pricing IPT.

5.3 Process

Changes to the TRICARE baseline are categorized as non-discretionary or discretionary. Approval processes are flowcharted in **Figures 2 and 3**. Three percent (3%) of the value of the managed care support contracts is budgeted on an annual basis for changes to the managed care support contracts. This budget is commonly referred to as the "wedge". Non-discretionary changes include medically necessary standard of care issues and recurring required operational changes. Non-discretionary changes are initiated by the Program Operations Directorate (POD), TMA Medical Directors or the Services. Coordination with the Service Medical Directors may be necessary. Due to the urgent and/or unavoidable nature of these changes, funds have been set aside for implementation. The HSDSG, RMSC and CMB are provided informational briefings on non-discretionary items actioned.

Discretionary changes encompass all other items. These changes or projects are facilitated within the PMO process and therefore go through the three phases of the Change Management process. The phases are:

- Requirements Generation Phase
- Contracting/Pricing Phase
- Change Implementation Phase

CHANGE MANAGEMENT PROCESS
for Non-Discretionary Changes

Figure 2

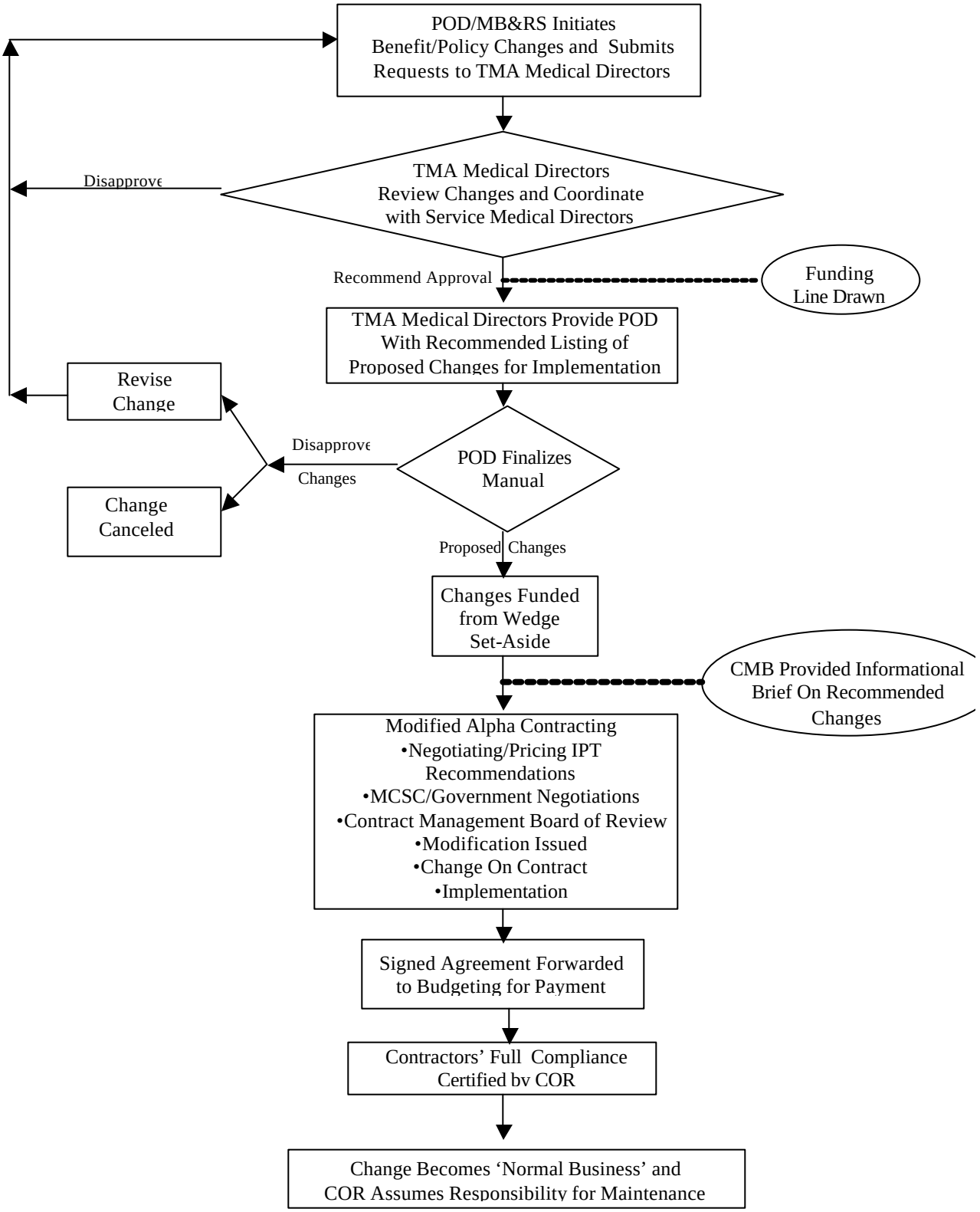
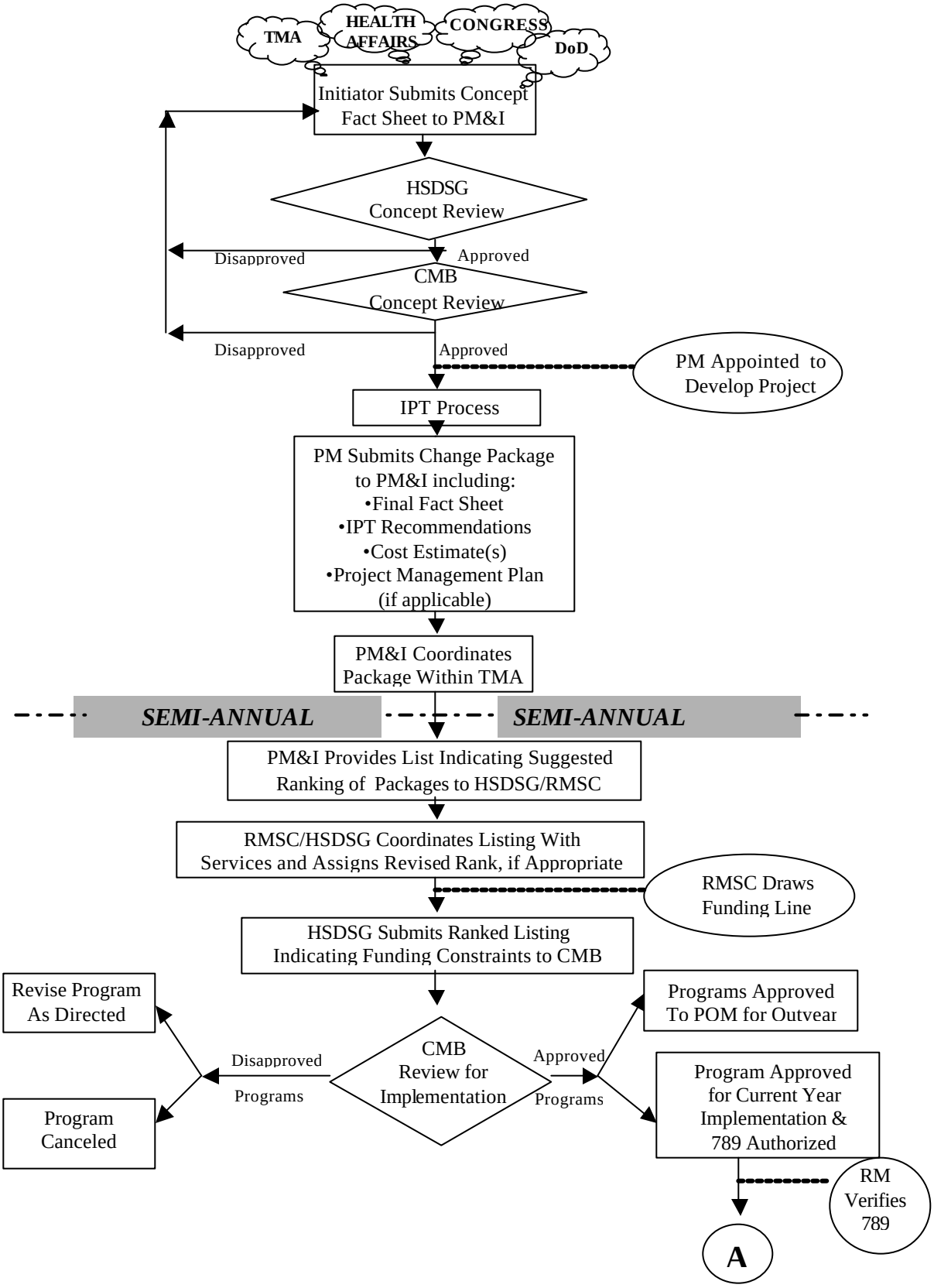
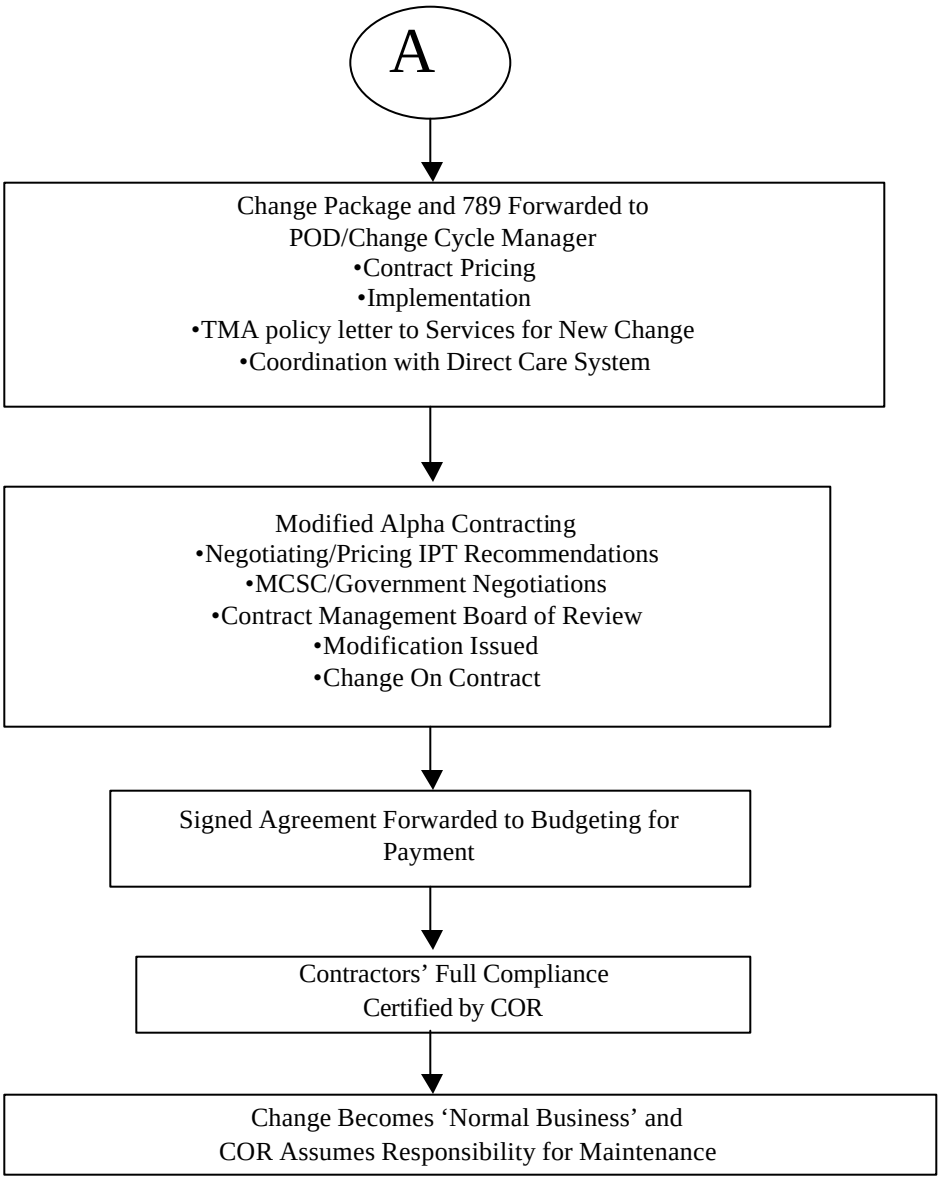


Figure 3

CHANGE MANAGEMENT PROCESS
for Discretionary Changes




A
Change Package and 789 Forwarded to
POD/Change Cycle Manager
•Contract Pricing
•Implementation
•TMA policy letter to Services for New Change
•Coordination with Direct Care System
Modified Alpha Contracting
•Negotiating/Pricing IPT Recommendations
•MCSC/Government Negotiations
•Contract Management Board of Review
•Modification Issued
•Change On Contract
Signed Agreement Forwarded to Budgeting for
Payment
Contractors' Full Compliance
Certified by COR
Change Becomes 'Normal Business' and
COR Assumes Responsibility for Maintenance

5.3.1 Phase I: Requirements Generation Phase

The requirements generation phase entails the identification and development of project needs. This phase may include policy development and approval to definitize the scope of the requirements. Appropriate stakeholders are pulled together to review the issues, assess alternatives and formulate costs. Phase stages include concept approval, project requirements & cost estimation and change package approval.

5.3.1.1 Concept Approval Stage

The change management process begins with the approval of the concept by the PEO and HSDSG. To obtain approval the project initiator must submit a Project Fact Sheet to the PM&I Office. The Fact Sheet includes a brief description of the proposed project and a preliminary cost estimate. Fact Sheet templates may be downloaded from the TRICARE website http://www.tricare/pmo/info/templates.html.

5.3.1.2 Project Requirements & Cost Estimation

Upon approval of the concept, a Project Manager (PM) is assigned to develop and refine project requirements. Using the Program Management Organization process, the PM forms an IPT consisting of personnel representing pertinent functions and directorates. After a general framework is developed, the PM will work through the Contracting Officer (CO) to bring in the managed care support contractor (MCSC), a third party independent estimator and government contracting and pricing staff. Through a series of meetings the team will refine project requirements and develop a rough order of magnitude (ROM). Additionally, the third party independent estimator will submit a cost estimate. Based on the ROM and the estimate from the independent third party, the PM determines the final costs and life cycle cost analyses to be included in the change package and recommended to the CMB.

5.3.1.3 Change Package Approval

The developed change request and supporting documentation is submitted as a package to the PM&I Office. At a minimum, the change package must include a completed Project Fact Sheet, cost estimates over the life of the project and proposed manual changes. Other documents such as the Business Plan and Project Management Plan (PMP) are at the discretion of the PM. The PM&I Office will coordinate the package through the TMA Directorates for feedback on direct care impacts.

Semi-annually, i.e. September and March, PM&I will submit a prioritized listing of change packages to the HSDSG for approval. The prioritization is based on legislation, direct care impact, expansion of the TRICARE benefit, organization optimization efforts and funding availability. The RMSC plays an integral role in helping the HSDSG balance these needs by delineating fiscal limitations and determining the Service fiscal splits. HSDSG will also solicit comments from the Services.

The HSDSG prioritized listing indicating fiscal constraints, i.e. the fiscal line, is then forwarded to the TRICARE CMB for review. If approved, the CMB will authorize the Resource Management (RM) Directorate to commit funding. All approved change packages including a completed funding document (Form 789) are handed over to the assigned POD Change Cycle Manager to begin implementation for that semi-annual cycle. Although the PM retains ultimate responsibility for the program's implementation, the focal point of activity transfers to the Change Cycle Manager. If a project is not approved for implementation during the cycle it was submitted, the PM&I Office will contact the PM regarding required action. The PM will be required to provide updated cost information and submit documents for the Planning, Programming and Budgeting System (PPBS) and Program Objective Memorandum (POM) process described in **Section 5.4** of this Guide.

5.3.2 Phase II: Contracting/Pricing Phase

The Contracting/Pricing Phase uses the team approach of alpha contracting principles. Alpha contracting is a concurrent process that results in a bilaterally negotiated supplemental agreement. (See **Appendix C** for more information on alpha contracting.) It is imperative that the PM stay in close contact with the Change Cycle Manager during the Contracting/Pricing Phase. The PM must be constantly aware of the project status and respond swiftly to any Change Cycle Manager requests. Delays may threaten the contracting window, cause significant difficulties in negotiations and subsequently result in the failure of the program's implementation.

The consolidated technical requirements are submitted to Contract Management who initiates a Pricing IPT with each MCSC. Simultaneously, the government will conduct evaluations through audits, technical reports, etc. As each area has been settled, it is written into the proposal and negotiated. Prior to execution of the modification or supplemental agreement, the CO must present the outcome of all negotiations valued over $500,000 to the Contract Management Board of Review. Afterwards, the completed change package can be issued on a modification and placed on contract. Work is authorized to begin.

5.3.3 Phase III: Change Implementation Phase

Upon receipt of the modification, the contractor will sign the necessary documents and begin implementation. When the signed modification is returned to Contract Management, it is certified and sent to Budgeting for payment. After the MCSC becomes fully compliant with the change to the contract, responsibility is transferred to Contracting Officer Representatives (CORs) for ongoing monitoring, quality assurance and surveillance. The change is now 'normal business' and falls within the auspices of the CORs' contract maintenance duties.

5.4 Planning, Programming & Budgeting System and Project Funding

The Planning, Programming & Budgeting System (PPBS) is the process by which TRICARE allocates project funding. The PM must ensure projects are approved by the CMB in time to be included in the appropriate budget cycle. The Resource Management directorate should be contacted to obtain dates on when submissions are due. It may also be necessary for the PM to update project costs if a project is approved for implementation in a fiscal year (FY) other than was originally planned.

With FY0 being the current year, PPBS budget vehicles are

FY Budget Impacted	Type	Development Schedule (New Budget)	Update Schedule (Revise Existing)	Modification Document
FY0	Wedge	Current FY	NA	NA
FY1 – FY2	Budget Estimate Submission (BES)	Every year	NA	Program Budget Decision (PBD)
FY3 – FY6	Program Objective Memorandum (POM)	Every even year	Every odd year	Program Decision Memorandum (PDM)

When TRICARE experiences a budget shortfall, e.g. underfunded legislative mandates, excess POM projects or urgent standard of care projects, the Resource Management Directorate and PM&I Office may coordinate requests for additional funding and work with the PM to assess business case analysis alternatives (Section 6.3).

SECTION **6**

Resource Funding

- *Program Management & Integration Office Funded Activities*
- *Project Budget Development*
- *Business Case Analysis*
- *Program Objective Management Submissions*
- *Budget Estimate Submissions and Execution Year Requirements*
- *Contracted Advisory Assistance Services & Non-Contracted Advisory Assistance Services Requirements*

6.1 Program Management & Integration Office Funded Activities

The PM&I Office provides the PM with several types of resources.

- Project Coordinator (support personnel)
- PM&I website development
- Office automation support
- Primavera Schedule development and tracking

All other support must be funded from the PM's project budget. If any questions arise regarding the activities funded by PM&I, contact the Director, Program Management & Integration Office for clarification.

6.2 Project Budget Development

The PM is responsible for identifying staffing and budget requirements for the assigned project. There are different funding requirements for which the PM is responsible for budgeting.

- Managed Care Support Contract changes
- Direct care impact of changes
- Project staffing
- Other direct costs (including DEERS support, IM/IT changes, etc.)

For the PM to be accountable and have leverage to keep the project on track, he/she needs to be responsible for preparing, programming, defending and executing a budget.

Each new project needs to submit a budget plan covering the duration of the project. The budget plan should include staff support and other direct costs (ODCs). The ODCs may be for expenses related to meetings, materials, equipment, speakers, IT system support, technical solutions, etc.

The PM should not direct implementation of a project until the project plan is approved and resources are identified. This includes efforts internal to DoD such as Defense Manpower Data Center - Defense Enrollment Eligibility Reporting Systems (DEERs) support.

The PM is also responsible for obtaining funds to ensure Change Orders are accomplished on the MCSCs. Please see the **Change Management Section** of this Guide for further information.

6.3 Business Case Analysis

When a project is being developed for approval, as many options as possible should be defined and priced out. The business case analysis should include

- Impact of not implementing the project
- Minimal requirements to meet potential legal liabilities
- Implementation with limited resources
- Implementation with optimal or full requirements
- Recommended project

All decision briefings should include this business case analysis and be coordinated with the Resource Management Directorate in advance.

6.4 Program Objective Memorandum Submissions

Every year TMA is responsible for submitting a Program Objective Memorandum (POM) which in turn means each PM must submit a POM Fact Sheet **(Appendix E)**.

POM development -

- Six-Year Long Range Budget - Covers objectives, planned activities and cost of each project
- Developed every two years (even years)
- Updated every second year (odd years)
- First two years of the POM will later be translated into the Budget Estimate Submission (BES)

6.5 Budget Estimate Submission and Execution Year Requirements

If a project is not resourced in the POM or requirements grow significantly above the approved project funding, the PM will be required to update the Project Fact Sheet for consideration in the BES.

Should the project have any unfunded requirements in the year of execution, the PM must brief the Resource Management Steering Committee and other TMA and/or Health Affairs senior leadership to resolve the discrepancy. This re-emphasizes the importance of not initiating a project until resources have been secured.

6.6 Contracted Advisory Assistance Services & Non-Contracted Advisory Assistance Services Requirements

Each TMA Directorate is responsible for budgeting on an annual basis for Contracted Advisory Assistance Services (CAAS) and non-CAAS requirements. In turn each PM is responsible for submitting any CAAS or non-CAAS requirements to his/her respective Directorate. The assigned Project Coordinator is capable of assisting in the development of necessary documents, i.e. fact sheets for each project.

CAAS are defined in the DoD Directive 4205.2, February 10, 1992 as:

> Services acquired by contract from non-governmental sources to support or improve organization policy development, decision-making, management and administration, or to improve the effectiveness of management processes or procedures.

CAAS may take the form of information, advice, opinions, alternatives analyses, evaluations, recommendations, training, or technical support. CAAS cannot be used for inherently governmental functions.

Non-CAAS requirements (DoD Directive 4205.2) include but are not limited to:

- Routine maintenance of systems, equipment, and software; routine administrative services; printing services; and direct advertising (media) services
- ADP and/or telecommunication functions and related services
- Clinical & medical services for direct healthcare

Funding for a project involving the following items should be addressed within each project budget, through the CAAS and non-CAAS process and coordinated with the PM's Directorate Budget POC.

- Staff extender support
- PC travel in support of the project
- Software or equipment purchases
- Conferences and summits

Contract personnel may be requested to travel in support of the Project Manager. The Project Manager must provide a written justification to the Director, Program Management and Integration (PM&I) Office requiring the contract personnel travel. In order for the travel to be approved, the Project Manager must provide the appropriate funding to cover all contract personnel travel costs.

Generally, the Project Manager should provide written justification and proof of funding availability more than two weeks prior to the desired travel date so that the most economical travel arrangements (e.g. plane tickets, hotel reservations, rental car) can be made.

Contract personnel are not allowed to reserve Government rates for air travel. However, if a Government invitational travel order **(Sample J)** is available, Government rates for hotel accommodations and other forms of travel (e.g. train, bus, car) may be available.

Contract personnel are entitled to per diem compensation as listed at the following GSA website: www.dtic.mil/perdiem.

SAMPLE J - TRAVEL ORDERS

Health Affairs Letterhead

<Contractor Personnel Name>
<Contractor Personnel Home Street Address>
<Contractor Personnel City, State, Zip Code>

Dear <Mr./Ms. Last Name>

You are invited to travel from <City, State> on <dd MM yyyy>, to <City, State> and return to <City, State> on or about <dd MM yy> for approximately <enter number of days> days of travel. The purpose of the travel is <enter purpose of travel> for the <enter project name>.

Travel by rail, military aircraft, commercial aircraft is limited to the most economical accommodations to satisfy mission requirements, as may be determined by the appropriate transportation officer and travel by privately owned conveyance at the rate of 34.5 cents per mile is authorized. Reimbursement for mileage by privately owned automobile will not exceed the cost of travel by the usual mode. Government rate rental care is authorized.

While en route and away from your home or place of business on the mission, your actual transportation expenses, including reimbursement for transportation not furnished in kind will be paid including per diem in lieu of subsistence in accordance with Volume 2 of the Joint Travel Regulations. Receipts and ticket stubs will be required to substantiate your claims for costs of transportation and subsistence for items in excess of $25.00. Address any inquiries regarding this travel order to <enter name of Project Manager> at <enter phone number>.

Submission of a travel claim is required within 15 days after completion of travel. Three copies of this invitational travel order must be attached to the travel claim when submitted. Approval under authority of DODD 5118.3. Travel claim is to be submitted to Ms. Sharon Edmonds, 5111 Leesburg Pike, Suite 810, Falls Church, VA 22041.

Social Security: <enter contract personnel social security number xxx-xxx-xxxx>

Sincerely,

<Project Manager signature block>

SECTION **7**

Appendices

- *Appendix A: Letter Instructional Templates*
  - *A-1: Project Manager, Co-Project Manager & Deputy Project Manager Appointment Letters*
  - *A-2: TMA Directorate & Service Representative Integrated Project Team Appointment Letters*
  - *A-3: Lead Agent Representative Integrated Project Team Appointment Letter*
- *Appendix B: Core Document Instructional Templates*
  - *B-1: Mission Needs Statement*
  - *B-2: Program Management Organization Business Plan*
  - *B-3: Project Management Plan*
- *Appendix C: Alpha Contracting*
- *Appendix D: Change Management Frequently Asked Questions*
- *Appendix E: Program Objective Memorandum Fact Sheet*
- *Appendix F: Integrated Project Team Charter Instructional Template*
- *Appendix G: Milestone Chart Instructional Template*

Appendix: A-1
Project Manager, Co-Project Manager and Deputy Project Manager Appointment Letters

MEMORANDUM FOR *<Name of Appointed PM, Title >*

SUBJECT: Project Manager Appointment for *<Name of Project>*

You are hereby appointed the Project Manager for *<Name of Project>*. You will be guided in your duties and responsibilities by the Department of Defense Regulation 5000.2-R and the TRICARE PMO User's Guide. Copies of both of these documents will be provided to you by the Director, Program Management and Integration Office during your "kick-off" briefing. *<insert the global mission of this project (1 sentence)>*.

As the TRICARE Project Manager for *<Name of Project>* you are responsible and accountable for coordinating the day to day activities of the project and for ensuring that the project progresses satisfactorily through the tailored TRICARE Program Management Organization (PMO) model. The Project Manager periodically reports status and progress to the TRICARE Program Executive Officer (PEO).

As the *<Name of Project>* Project Manager you are specifically responsible for:

- serving as the Chair of the *<Name of Project>* Integrated Project Team (IPT);
- managing the project in a manner consistent with the policies and principles articulated by the TRICARE PEO;
- briefing the IPT recommended project schedule to the TRICARE PEO for approval;
- providing assessments of project status and risk reporting variances to the TRICARE PEO;
- monitoring cost, performance and schedule;
- managing the risk for the project by allocating resources, executing risk management, and ensuring interaction and communication between team members;
- overseeing the development of the necessary project and acquisition documentation to execute the project (e.g., Mission Needs Statement, Project Management Plan, etc.);
- ensuring that the appropriate stakeholders are actively engaged in the project;
- representing the project at intra-agency and inter-agency meetings;
- coordinating project actions with the other organizations as necessary.

This assignment expires when *<add specific information regarding when the project will end>* or, at the request of the TRICARE PEO.

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

cc:
Ms. Cheryl Kaminska
<name of Director>
<name of supervisor>

MEMORANDUM FOR *<Name of Appointed Co-PM, Title >*

SUBJECT: Co-Project Manager Appointment for *<Name of Project>*

You are hereby appointed the Co-Project Manager along with *<Other Co-PM's name>* for *<Name of Project>*. You will be guided in your duties and responsibilities by the Department of Defense Regulation 5000.2-R. and TRICARE PMO User's Guide. Copies of these documents will be provided to you by the Director, Program Management and Integration Office during your Program Management Organization (PMO) "kick-off" brief. *<Insert the global mission of this project (1 sentence)>*.

As the TRICARE Co-Project Manager for *<Name of Project>* you are responsible and accountable for coordinating the day to day activities of the project and for ensuring that the project progresses satisfactorily through the tailored TRICARE PMO model. The Co-Project Managers periodically report status and progress to the TRICARE Program Executive Officer (PEO).

As the *<Name of Project>* Co-Project Manager you are specifically responsible for:

- serving as the Co-Chair of the *<Name of Project>* Integrated Project Team (IPT);
- managing the project in a manner consistent with the policies and principles articulated by the TRICARE PEO;
- briefing the IPT recommended project schedule to the TRICARE PEO for approval;
- providing assessments of project status and risk reporting variances to the TRICARE PEO;
- monitoring cost, performance and schedule;
- managing the risk for the project by allocating resources, executing risk management, and ensuring interaction and communication between team members;
- overseeing the development of the necessary project and acquisition documentation to execute the project (e.g., Mission Needs Statement, Project Management Plan, etc.);
- ensuring that the appropriate stakeholders are actively engaged in the project;
- representing the project at intra-agency and inter-agency meetings;
- coordinating project actions with the other organizations as necessary.

This assignment expires when *<add specific information regarding when the project will end>* or, at the request of the TRICARE PEO.

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

cc:
Ms. Cheryl Kaminska
<name of Director>
<name of supervisor>

MEMORANDUM FOR <*Name of Deputy Project Manager Name and Title*>

SUBJECT: Deputy Project Manager Appointment for the <*Name of Project* >

You are hereby appointed the Deputy Project Manager <*Name of Project*>. You will be guided in your duties and responsibilities by the Department of Defense Regulation 5000.2-R and the TRICARE PMO User's Guide. The Director, Program Management and Integration Office will provide copies of these documents to you. <*insert the global mission of this project (1 sentence*)>.

As the TRICARE Deputy Project Manager for <*Name of Project*> you are responsible and accountable for coordinating the day to day activities of the project and for ensuring that the project progresses satisfactorily through the tailored TRICARE Program Management model. The Project Manager and Deputy Project Manager periodically reports status and progress to the TRICARE Program Executive Officer (PEO).

As the <*Name of Project*> Deputy Project Manager you are specifically responsible for the following when the Project Manager is not available:

- may be requested to serve as the chair of the <*Name of Project*> Integrated Project Team (IPT) periodically;
- managing the project in a manner consistent with the policies and principles articulated by the TRICARE PEO;
- briefing the IPT recommended project schedule to the TRICARE PEO for approval;
- providing assessments of project status and risk reporting variances to the TRICARE PEO;
- monitoring cost, performance and schedule;
- managing the risk for the project by allocating resources, executing risk management, and ensuring interaction and communication between team members;
- overseeing the development of the necessary project and acquisition documentation to execute the project (e.g., Mission Needs Statement, Project Management Plan, etc.);
- representing the project at intra-agency and inter-agency meetings;
- coordinating project actions with the other organizations as necessary.

This assignment expires when <*add specific information regarding when the project will end*> or, at the request of the TRICARE PEO.

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

cc:
Ms. Cheryl Kaminska
<*name of Director*>
<*name for supervisor*>

Appendix A-2:
TMA Directorate and Service Representative Integrated Project Team Appointment Letters

MEMORANDUM FOR DEPUTY SURGEON GENERAL OF THE ARMY
DEPUTY SURGEON GENERAL OF THE NAVY
DEPUTY SURGEON GENERAL OF THE AIR FORCE

SUBJECT: Request for Appointment of Integrated Project Team Representative for the *<Name of Project>*

Your participation is requested in developing the *<Name of Project>*. The project will *<Insert statement on purpose of project>*.

As the TRICARE Program Executive Officer, I have directed the formation of an Integrated Project Team (IPT) comprised of representatives from the Services and functional areas within the TRICARE Management Activity (TMA). The IPT shall work collaboratively to address all issues regarding requirement development of the project.

You are requested to appoint an individual from your Service to serve on this IPT. The individual should have the requisite knowledge and expertise to address the development and implementation of the functional and operational requirements needed to carry out this project. The IPT begins *<Month & Year>*, and expires at the *<time Project End solution>*. The length of the IPT is estimated to extend approximately *<months>*. It is desired for continuity purposes that the person appointed be able to serve throughout the development of the project.

I have attached a sample of an appointment memorandum for your guidance. Any such appointment memorandum should clearly state the expectations, responsibilities and authority of your representative. Please forward a copy of your appointment memorandum to me by two (2) weeks from the date of this memorandum. If you have any questions, please contact *<project manager>*, *<project name>*, *<phone>* or by email *<email address>*.

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

Attachment:
Sample IPT Appointment Memorandum

cc:
Ms. Cheryl Kaminska
<Project Manager's name>

SAMPLE

MEMORANDUM FOR (FILL IN)

SUBJECT: Expectations and Responsibilities of Integrated Project Team (IPT) Members

1. I have nominated you to serve as the (Branch of Service) Medical Department representative on the (Fill-in) IPT that has been formed by the TRICARE Program Executive Officer under the supervision of the Program Management Office, TRICARE Management Activity (TMA). This appointment identifies you as a functional expert on the matters the IPT is addressing.

2. The purpose of this memorandum is to let you know my expectations of you as an IPT member. First, I expect you to provide the IPT your well thought out functional opinions of the issues. Second, you are the (Service) action officer for the issues of the IPT you support. I expect you to fully staff this action. You are responsible for keeping the appropriate staff members informed of the IPT's progress and potential impacts. Coordination will prevent surprise when HA/TMA publishes a policy or begins a project related to your IPT. Finally, you are responsible for keeping me informed on the status of your IPT by reporting to me through your appropriate chain of command using enclosure (1). Accomplishing this process in a timely manner will speed formal HA/TMA staffing within our department.

3. There is a limitation concerning your role as an IPT member. The Project Manager may interpret your opinions to be the (Service) position on a particular issue. The limitation is that your opinions are functional ones until the (Service) leadership approves a position. You must anticipate the requirement for a (Branch of Service) position and act to ensure a timely decision.

4. Your role in this process of managing complex and dynamic issues is very important. I look forward to seeing your work on these significant issues. Any questions you have regarding your responsibilities or limitations should be addressed to (fill in) who may be reached at (telephone number) or email (email address).

The Surgeon General

cc:
Executive Director, TMA
Deputy Surgeon General
TMA Project Manager

SAMPLE INFORMATION PAPER

Code
Date

SUBJECT: To Provide a Status Update on the (Name of IPT)

1. ISSUE: Provide a brief background and description of the IPT requirement.

2. FACTS:

    a. Ensure smooth, logical flow of facts.

    b. Describe the potential impact of the issues (Clinical, financial, human resources).

    c. Papers should not exceed two pages in length and need not be signed, but must include the IPT member's name and telephone number in the lower right corner. Include an approval line below the IPT member's name to indicate appropriate approval.

    d. Describe significant timeline issues and decision points. Attach a copy of the current milestone chart.

    e. Describe other Service positions, HA/TMA positions, and other interested parties (i.e., Congress) positions as appropriate.

    f. If approved, state the (Service) position.

    g. The IPT information paper is submitted within 24 hours after each IPT meeting or as a minimum updated the 1st of every month or more often as determined by decision points. Submit information papers to The Surgeon General through the appropriate Assistant Surgeon General and Deputy Surgeon General.

3. RECOMMENDATIONS:

    a. Recommend a (Service) position if it is not established

    b. Other recommendations you consider appropriate

MEMORANDUM FOR DIRECTOR, ACQUISITION MANAGEMENT & SUPPORT
DIRECTOR, COMMUNICATIONS & CUSTOMER SERVICE
DIRECTOR, HEALTH PROGRAM ANALYSIS & EVALUATION
DIRECTOR, INFORMATION MANAGEMENT, TECHNOLOGY & REENGINEERING
DIRECTOR, OPTIMIZATION & INTEGRATION
DIRECTOR, PROGRAM OPERATIONS
DIRECTOR, RESOURCE MANAGEMENT

SUBJECT: Appointment of Integrated Project Team Representative for <*name of project*>

Your support is requested in the development and implementation of deliverables for the <*name of project*>. This team will <*Insert statement on purpose of project*>.

As the TRICARE Program Executive Officer, I have directed the formation of an IPT to be comprised of representatives from the Services and functional areas within the TRICARE Management Activity (TMA). The IPT shall work collaboratively to address all issues regarding <*name of project*>.

I request that you appoint an individual from your Directorate to serve on this IPT. The individual should have the requisite authority and expertise to speak for your functional or operational area considering the project's scope. If you feel that a full time IPT representative from your Directorate is not necessary, please provide a point of contact to attend IPT meetings on an as needed basis. If you have any issues or concerns, which should be, addressed by the IPT, please contact the Project Manager, <*name of PM*>. The IPT begins <*Month & Year*>, and expires upon <*identification of deliverables – Project end*>, anticipated <*timeframe*>. The length of the IPT is estimated to extend approximately <*mont*hs>. It is desired for continuity purposes that the person appointed be able to serve throughout the development and implementation of the improved processes.

In your appointment memorandum, please use language that clearly describes the authority and limitations of authority that the appointed IPT member possesses. Please submit a copy of your appointment memorandum to me within two (2) weeks from the date of this memorandum. If you have any questions, please contact <*PM, name of project*>, at <*telephone number and email*>.

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

cc:
Ms. Cheryl Kaminska
<*Project Manager*>

Appendix A-3:
Lead Agent Representative
Integrated Project Team
Appointment Letter

MEMORANDUM FOR TRICARE LEAD AGENT

SUBJECT: Request for Appointment of Integrated Project Team Representative for the *<Name of Project>*

Your participation is requested in developing the *<Name of Project>*. The project will *<Insert statement on purpose of project>*.

As the TRICARE Program Executive Officer, I have directed the formation of an Integrated Project Team (IPT) comprised of representatives from the Services and functional areas within the TRICARE Management Activity (TMA). The IPT shall work collaboratively to address all issues regarding requirement development of the project.

You are requested to appoint an individual from your Lead Agent to serve on this IPT. The individual should have the requisite knowledge and expertise to address the development and implementation of the functional and operational requirements needed to carry out this project. The IPT begins *<Month & Year>*, and expires at the *<time Project End solution>*. The length of the IPT is estimated to extend approximately *<months>*. It is desired for continuity purposes that the person appointed be able to serve throughout the development of the project.

I have attached a sample of an appointment memorandum for your guidance. Any such appointment memorandum should clearly state the expectations, responsibilities and authority of your representative. Please forward a copy of your appointment memorandum to me within two (2) weeks from the date of this memorandum. If you have any questions, please contact *<project manager, phone/fax number>* or by email *<email address>*.

Leonard M. Randolph, Jr.
Major General, USAF, MC
Deputy Executive Director

Attachment:
Sample IPT Appointment Memorandum

cc:
Lead Agent Director
Ms. Cheryl Kaminska
<Project Manager name>

SAMPLE

MEMORANDUM FOR (FILL IN)

SUBJECT: Expectations and Responsibilities of Integrated Project Team (IPT) Members

I have nominated you to serve as the (Branch of Service) Medical Department representative on the (Fill-in) IPT that has been formed by the TRICARE Program Executive Officer under the supervision of the Program Management Office, TRICARE Management Activity (TMA). This appointment identifies you as a functional expert on the matters the IPT is addressing.

The purpose of this memorandum is to let you know my expectations of you as an IPT member. First, I expect you to provide the IPT your well thought out functional opinions of the issues. Second, you are the (Service) action officer for the issues of the IPT you support. I expect you to fully staff this action. You are responsible for keeping the appropriate staff members informed of the IPT's progress and potential impacts. Coordination will prevent surprise when HA/TMA publishes a policy or begins a project related to your IPT. Finally, you are responsible for keeping me informed on the status of your IPT by reporting to me through your appropriate chain of command using enclosure (1). Accomplishing this process in a timely manner will speed formal HA/TMA staffing within our department.

There is a limitation concerning your role as an IPT member. The Project Manager may interpret your opinions to be the (Service) position on a particular issue. The limitation is that your opinions are functional ones until the (Service) leadership approves a position. You must anticipate the requirement for a (Branch of Service) position and act to ensure a timely decision.

Your role in this process of managing complex and dynamic issues is very important. I look forward to seeing your work on these significant issues. Any questions you have regarding your responsibilities or limitations should be addressed to (fill in) who may be reached at (telephone number) or email: (email address).

The Surgeon General

cc:
Executive Director, TMA
Deputy Surgeon General
TMA Project Manager

SAMPLE INFORMATION PAPER

Code
Date

SUBJECT: To Provide a Status Update on the (Name of IPT)

ISSUE: Provide a brief background and description of the IPT requirement.

FACTS:

a. Ensure smooth, logical flow of facts.

b. Describe the potential impact of the issues (Clinical, financial, human resources).

c. Papers should not exceed two pages in length and need not be signed, but must include the IPT member's name and telephone number in the lower right corner. Include an approval line below the IPT member's name to indicate appropriate approval.

d. Describe significant timeline issues and decision points. Attach a copy of the current milestone chart.

e. Describe other Service positions, HA/TMA positions, and other interested parties (i.e., Congress) positions as appropriate.

f. If approved, state the (Service) position.

g. The IPT information paper is submitted within 24 hours after each IPT meeting or as a minimum updated the 1st of every month or more often as determined by decision points. Submit information papers to The Surgeon General through the appropriate Assistant Surgeon General and Deputy Surgeon General.

4. RECOMMENDATIONS:

h. Recommend a (Service) position if it is not established

i. Other recommendations you consider appropriate

Appendix B-1:
Mission Needs Statement
Instructional Template

Mission
Needs Statement
Instructional Template

Note to the Reader

You are encouraged to tailor the template and make additions or subtractions, as your professional judgement deems necessary. Through this activity, keep in mind that this document is central to a successful project and requires thoughtful deliberation, meaningful participation and careful documentation.

While using this template, please be aware that *plain italicized text* indicates instruction, direction, or a suggestion.

Mission Needs Statement
For
< Project Name >

This Mission Needs Statement (MNS) describes the required operational capabilities (mission or purpose) for <project name>. The MNS identifies major project objectives to which the need responds. If the MNS is carefully prepared to address the project's end result objectives, future decisions concerning milestones, high-level activities and evaluation pieces may be easier to finalize.

This document should be tailored to meet your project's specific requirements, but should follow the attached guidelines.

This MNS contains the following sections:

1) Background

2) Statement of Need

3) Major Project Objectives

4) Key Constraints (if applicable)

5) Duration of Project

Approval

I. BACKGROUND

In one or two paragraphs, the background section should familiarize the reader with the project's Department of Defense (DoD) background.

- *How was the project initiated? Was the project Congressionally mandated, approved by the TMA Executive Director, or proposed as an issue that needed to be addressed by way of program management techniques?*

  Example:

  Medical and Personnel leaders meeting at the 2 June 99 Medical/Personnel Issues Forum came to the consensus that the link between the Personnel and Medical communities (and systems) could be strengthened in a manner to provide better service and communication with the consumer. This project, earmarked by the TRICARE Program Executive Officer (PEO), will determine

a suitable methodology to facilitate the interface of the Personnel and Medical communities.

II. STATEMENT OF NEED

The statement of need should clearly explain the program's mission need and operational requirements (where necessary).

A. MAJOR PROJECT OBJECTIVES

This portion of the mission needs statement should establish the main focus of the IPT and clearly state the end vision without presupposing a specific solution.

- *What are the major objectives and desired outcomes of this IPT?*
- *What benefit or need will these objectives be satisfying?*

B. KEY CONSTRAINTS (optional)

This section describes any key boundaries or conditions related to the project that may impact satisfying its mission. It is important to identify potential problems that might impede the effectiveness or success of the project. For example:

> *The MCS contracts are being renewed in many of the regions. Any policy or requirements that are made within the course of the Enrollment IPT Charter must take this into consideration and evaluate the timing of the potential changes, weighing the benefits with the impact that it may have on the contracts that are currently in place at each of the regions.*

C. DURATION

In one paragraph, briefly state how long the project will last. The proposed end date from the project charter should be included, as well as any exit criteria or major deliverables that would signify completion of this project.

III. APPROVALS

Project Manager	**Date**
Co/Deputy Project Manager (if applicable)	**Date**
TRICARE Program Executive Officer	**Date**

Appendix B-2:
Program Management Organization
Business Plan
Instructional Template

Program Management Organization Business Plan

Instructional Template

Note to the Reader

You are encouraged to tailor the template and make additions or subtractions, as your professional judgement deems necessary. Through this activity, keep in mind that this document is central to a successful project and requires thoughtful deliberation, meaningful participation and careful documentation.

While using this template, please be aware that *plain italicized text* indicates instruction, direction, or a suggestion.

Program Management Organization
Business Plan
For
< Project Name>

This Program Management Organization (PMO) Business Plan presents the processes by which <project name> shall be managed. This document's components include:

1) Participants' Roles and Responsibilities

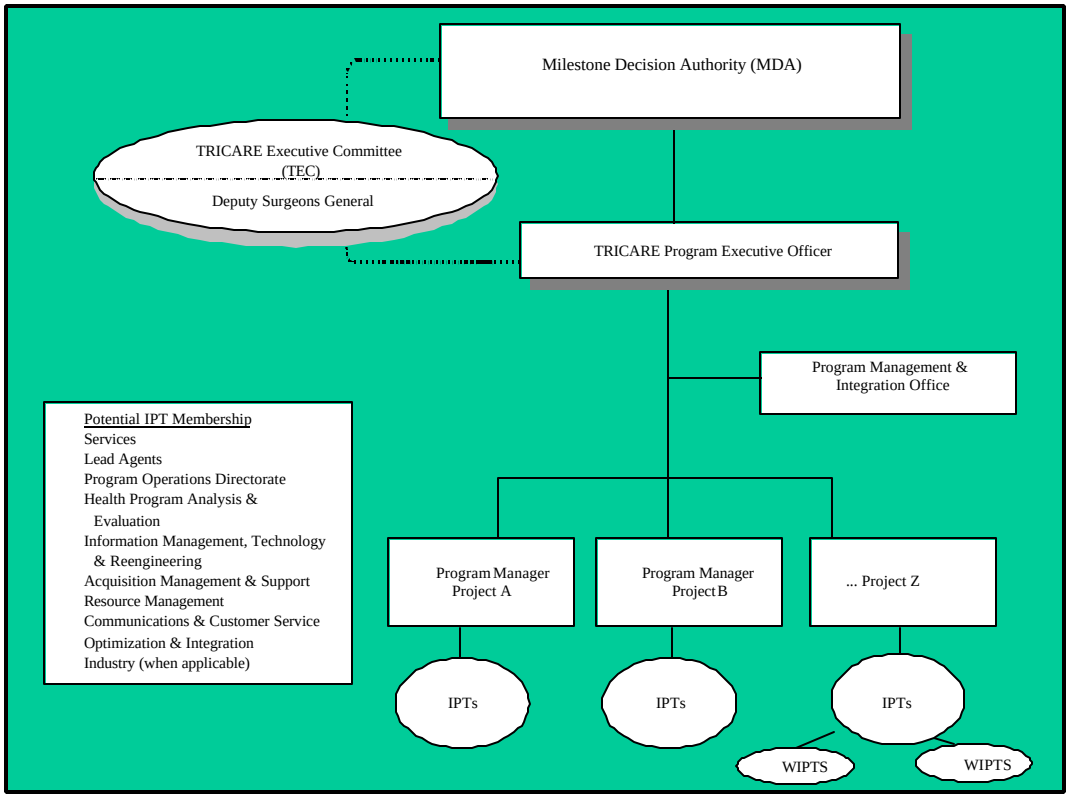
2) Business Rules
   - Participation
   - Flow of Activity
   - Communication Protocol

3) Relationship between the Contract Management and Program Management Activities

I. Organizational Responsibilities and Relationships

The chart below (Figure 1.0) depicts the decision making hierarchy and the relationship between the TRICARE Program and the projects. The roles and responsibilities of participants and organizations are detailed after the chart.

Figure 1.0
TRICARE Program Management Oversight



Once the overall direction and milestones are established by the Milestone Decision Authority (MDA), execution of the TRICARE Program operates as a "bottom up" activity – all execution decisions are made at the lowest appropriate level possible. Issues that cannot be resolved are elevated to the next level within the organization through completion. Ultimately, the MDA has the final decision authority for the TRICARE Program.

The titles and respective responsibilities are listed below:

Milestone Decision Authority (MDA)

The ***TRICARE Milestone Decision Authority (MDA)*** is the final authority for all TRICARE related activities. The MDA approves the advancement of a project from one phase to another. The MDA provides direction, oversight and final approval to all projects.

TRICARE Executive Committee (TEC)

The ***TRICARE Executive Committee (TEC)*** serves as an advisory committee at the request of the MDA or the Program Executive Officer. Its membership includes the Service Surgeons General. The TEC may serve as a sponsor or proponent for a project and as a liaison between Service constituents and the MDA, TRICARE Management Activity (TMA), and/or Program Executive Officer.

Deputy Surgeons General (DSGs)

The ***Deputy Surgeons General (DSGs)*** serve as a first level advisory committee and review projects and timelines as presented by Project Managers. The DSGs also provide input from the Service perspective through the nomination of Service representatives and participants.

TRICARE Program Executive Officer (PEO)

The ***TRICARE Program Executive Officer (PEO)*** is primarily responsible for oversight and management of the planning, integration, and coordination of one or multiple projects that fall under TRICARE Program Management. Depending upon scope and complexity, projects may be assigned to full-time PMs by the TRICARE PEO. The TRICARE PEO is accountable to the MDA for delivering a quality deliverable project on schedule and within cost. He/she reports progress and issues regularly to the MDA. The PEO determines which programs/projects will require oversight and assignment under Program Management.

Resource Management Steering Committee (RMSC)

The ***TRICARE Resource Management Steering Committee (RMSC)*** membership includes Senior Comptrollers from each Service component served by the Defense Helath Program (DHP). The TMA Deputy Director for Resource Management chairs the committee. In coordination with the Health Services Delivery Steering Group, the RMSC makes project funding recommendations. The group also reviews cost estimates submitted with change packages.

Health Services Delivery Steering Group (HSDSG)

The ***Health Services Delivery Steering Group (HSDSG)*** is comprised of senior representatives from each of the Services and TMA Chief of Staff. The group reviews updates from TRICARE Integrated Project Teams and ensures the respective DSGs are properly informed of TRICARE projects.

TRICARE Management Activity (TMA) Directors

The ***TRICARE Management Activity (TMA) Directors*** are responsible for the oversight and management of the TMA directorates. The Directors are accountable for the performance of the Project Managers from their directorates and are responsible for knowing IPT progress through reports from their respective PMs and IPT members. All TMA Directors will be assigned as a counselor to certain project to track progress, milestone achievement and provide guidance to the Project Managers.

Program Management Organization (PMO)

The ***Program Management Organization (PMO)*** is the management process that is used to structure and execute TRICARE Projects. The PMO process was established to develop a centralized business approach using concepts from the DoD 5000 series and then was tailored to TRICARE.

Program Management & Integration (PM&I) Office

The ***Program Management & Integration (PM&I) Office*** provides an approved program management model for TRICARE and adds structure and processes, where appropriate, to meet the execution and integration requirements of projects assigned under the TRICARE PMO discipline. This office provides consultants to facilitate issue resolution, monitor project development and track timelines/milestones. Reports and updates are provided on a routine basis to the PEO to obtain concurrence. When appropriate, the PM&I staff facilitates the integration of PMO projects to ensure all aspects of TRICARE projects are supportive and complementary.

Project Manager (PM)

The ***Project Manager (PM)*** is appointed in writing by the PEO. The PM/PO is responsible for the planning, integration, management and execution of day-to-day activities associated with meeting the project mission, schedule, cost, and deliverables. He/She is ultimately responsible for the completion of mandatory and discretionary documents and activities, and reports project progress to the PEO on a regular basis. The PM/PO coordinates issue resolution through the Integrated Project Team appointed to the

project. The PM/PO determines the team composition, meeting frequency and strategic direction. Consultation with the Director, PM&I is available as needed.

Project Coordinator (PC)

The ***Project Coordinator (PC)*** is assigned to a particular project by the PM&I Office. The PC is responsible for providing quality program management support by assisting the PM with the activities, issues, decision-making, communications, reporting and overall management of the Integrated Project Team. The PC provides analytical, technical, and logistical support by documentation and tracking project activities, deliverables and briefing schedules. The PC consults with the PM on a regular basis to assist with the program's day-to-day activities. PC support functions cease when Integrated Project Team work is completed.

Integrated Project Team (IPT)

The ***Integrated Project Team (IPT)*** facilitates teamwork and collaborative decision making to generate recommendations related to the assigned project objectives. Each member represents a functional area or contributes subject matter expertise to meet the project deliverable. Composition will be determined by the scope and complexity of the project, along with staffing needed to support the PM in the management of the project. Membership on the IPT consists of senior staff officers within the TMA Directorates, Services, and Lead Agent Offices and other organizations as identified by the PM.

Working Integrated Project Team (WIPT)

The ***Working Integrated Project Team (WIPT)*** is responsible for specific issue resolution as assigned by the PM. Potential issues are forwarded to the PM for dissemination to the WIPT chair. WIPTs are appointed and empowered by their work area and participate in resolving specific issues related to the PMO project. WIPTs may work a specific issue for the IPT and present a recommended solution and/or alternatives for IPT consideration and action.

TRICARE Management Activity (TMA) Services and Lead Agents *(LAs)*

The ***TRICARE Management Activity (TMA) Services and Lead Agent (LAs)*** are responsible for providing qualified, empowered staff to participate in the TRICARE PMO project as IPT or WIPT members. As team members, this staff may be asked to determine joint requirements, provide schedules and project deliverables, facilitate various sub-projects, and evaluate or provide comments on projects at various stages of delivery. These representatives are expected to serve as liaisons to their appointing organizations and to coordinate feedback with the Director and PMs at regularly scheduled intervals.

Discuss how this project will employ IPTs. What groups will be represented? Will there be more than one person from each group? Will members from agencies outside of TMA be utilized?

In describing your IPT composition, include the specific roles and functions of each IPT member as it pertains to your project.

Example:

> *The Enrollment IPT will consist of two members from the HPA&E Directorate. One HPA&E member is a Deputy PM for another IPT whose mission is directly impacted by the actions of the Enrollment IPT. This individual will act as the integration nexus and coordinate information between these two IPTs to ensure consistency and non-duplicity of effort. The other HPA&E member has performed extensive site studies on enrollment thresholds in given catchment areas and is most capable in developing metrics and measuring the performance of the initiatives enacted by the Enrollment IPT.*

WORKING INTEGRATED PROJECT TEAMS (WIPTS)

WIPTs are working teams represented by cross-functional disciplines. IPTs form a WIPT to analyze a specific issue and recommend potential solutions when input from more than one organization or functional discipline is needed. The director or head of each agency or operation will typically appoint WIPT members. WIPTs should be formed to address a single issue and work on the issue for a shorter time period than an IPT.

There may be many WIPTs formed for a single project to address diverse issues. For example, when a new release of a managed care contract incorporates new information system requirements, the IPT may assign a WIPT to develop the cost estimate of the new requirement. A WIPT, comprised of representatives from the Military Health Systems Operations and the Information Management, Technology and Reengineering Office would work to define the functional requirements, develop a feasible technical solution, and develop a cost estimate.

When a particular organization is tasked to respond to an issue, and the scope of the issue is within that of the organization, (no other functional representation is required); a WIPT is not formed. For example, procuring a pharmacy software system requires an Acquisition Strategy. The IPT member from the Acquisition Management and Support (AM&S) office would assign members of their staff to prepare the document. This would not be an example of a WIPT, because the preparation of an Acquisition Strategy falls within the normal scope of AM&S activities. Input from other functional organizations is not required.

Discuss how this project will employ WIPTs. What groups will be represented? Will there be more than one? Will you use existing groups? Will you establish WIPTs by functional assignments (e.g., Acquisition WIPT, Finance WIPT) or by a specific

deliverable or task (e.g., Develop Statement of Objectives)? Who will be on these WIPTs, and why is their representation needed?

II. BUSINESS RULES

The following rules guide the project participants through the day-to-day management and operation involving the <project name>.

A. PARTICIPATION

The following portion is only applicable to procurement-sensitive projects:

All Government and TMA support contractor participants must execute a Confidentiality Statement (CS) prior to receiving any project management sensitive information. Integrated Project Team (IPT) members not privy to project management sensitive information are not required to sign the document. They must, however, receive a CS and acknowledge that they understand and will comply with the stated requirements. All new participants will be directed to the Project Manager (PM) who will issue the CS. The original is kept by the PM, who will maintain the list of authorized participants.

Procurement sensitive documents will be provided on a need to know basis only. Procedures to protect this information must be observed at all times. Prior to all meetings, attendees will be screened against the list of authorized participants. In the event a participant does not abide by the stated requirements, the PM may remove that individual from this project.

Depending on the scope of the project, a Co-Project Manager or Deputy Project Manager may be assigned to provide additional management support. In this instance, the manager may delegate confidentiality documentation duties to the Co-Project Manager or Deputy Project Manager (if applicable).

Attendance at IPT meetings is normally limited to IPT members and those directly invited by the PM. Attendance at Working Integrated Project Team (WIPT) meetings is limited to WIPT members and direct invitations from the WIPT chair.

There may be meetings with participation from other areas within the TRICARE Management Activity; core PM&I staff that may consist of Government, military, and/or contractors; staff from the Surgeons General offices, or other designated offices. The PM may invite the individual(s) to attend specific meetings. The PM will be responsible for ensuring the invited personnel are instructed on the TRICARE PMO business rules regarding project sensitive information, if applicable. IPT members may also recommend to the PM that an individual or group attend a meeting(s) to assist in issue resolution.

IPT members should identify an individual from their workspace to serve as an alternate IPT member for those meetings they cannot attend. While alternate IPT members will not be required to attend or participate in regularly scheduled IPT meetings and tasking, they will be responsible for compliance with the rules identified in this Business Plan. In the event a discussion at an IPT meeting results in a vote, alternate IPT members may provide input but may not serve as a voting member.

B. FLOW OF INFORMATION

All items, e.g., contracts requirements, documents, questions, comments, information requests and issues, concerning the various areas that comprise a specific program's management plan or regarding the status of the project will be initially directed to the PM unless otherwise delegated by the PM to a designated IPT member. With the assistance of the Project Coordinator, the PM will keep a log detailing: the information source, date received, date resolved, action officer (either an individual, IPT, or WIPT), status and disposition. The PM will not release any information regarding the <project name> to unauthorized participants unless a need to know exists.

C. COMMUNICATION PROTOCOL (FOR PROCUREMENT SENSITIVE INFORMATION ONLY)

E-mail communication within the Health Affairs/TRICARE Management Activity (HA/TMA) Network is secure for sensitive information and authorized provided that:

- The email has "Procurement Sensitive" legibly printed at the top and bottom of the communication;
- All recipients have a need to know and have agreed to the terms of the Confidentiality Statement (CS);
- No recipient is located outside of the TMA Local Area Network (LAN);

The transfer of documents and files sent to authorized participants outside of the HA/TMA network must be accomplished using traditional safeguarding measures such as approved Courier Services (i.e., Federal Express) unless a secure email communication channel with encryption has by approved by the PM.

Any questions regarding these procedures should be forwarded to the PM who will resolve the issue.

III. RELATIONSHIP BETWEEN PM&I OFFICE AND PROGRAM MANAGEMENT ACTIVITIES

Program Management & Integration activities will be coordinated through the PM&I Office to ensure the successful completion of all initiatives identified for management and oversight by the PMO. Support will be primarily provided by

the Project Coordinators. The objectives of the collaboration are to eliminate duplication of effort between the multiple activities, share information, integrate Program Management projects and projects, and to secure the efficient production of identified deliverables. All activities will use a teamwork approach to identify issues, resolve those issues, and keep the deliverables on a schedule to meet established milestones.

IV. APPROVALS:

Project Manager	**Date**
Co/Deputy Project Manager (if applicable)	**Date**
TRICARE Program Executive Officer	**Date**

Appendix B-3:
Project Management Plan
Instructional Template

Project Management Plan
Instructional Template

Note to the Reader

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While using this template, please be aware that *plain, Italicized text* indicates instruction, direction, or a suggestion.

I. OVERVIEW

This Project Management Plan (PMP) provides a roadmap for developing and executing the <project name> Project. It addresses the strategies, roles, responsibilities, plans, milestones, and issues appropriate to the project office's management activities, and it identifies the impact of the project on the TRICARE Program.

Are there any unique characteristics about your project that you would like to highlight?

II. OBJECTIVE

Define the overall project objective. This can be a one or two sentence description of your projects overall mission.

III. SCOPE

Describe, in general terms, the project scope, i.e. the boundaries of the project. For example, is the project limited to an MTF, is it DoD/MHS-wide or is it interagency. Also, list the names of other projects that may be impacted by this project.

Information for the objective and scope should be consistent with what is found in the Mission Needs Statement for this project

IV. PROJECT STRATEGY

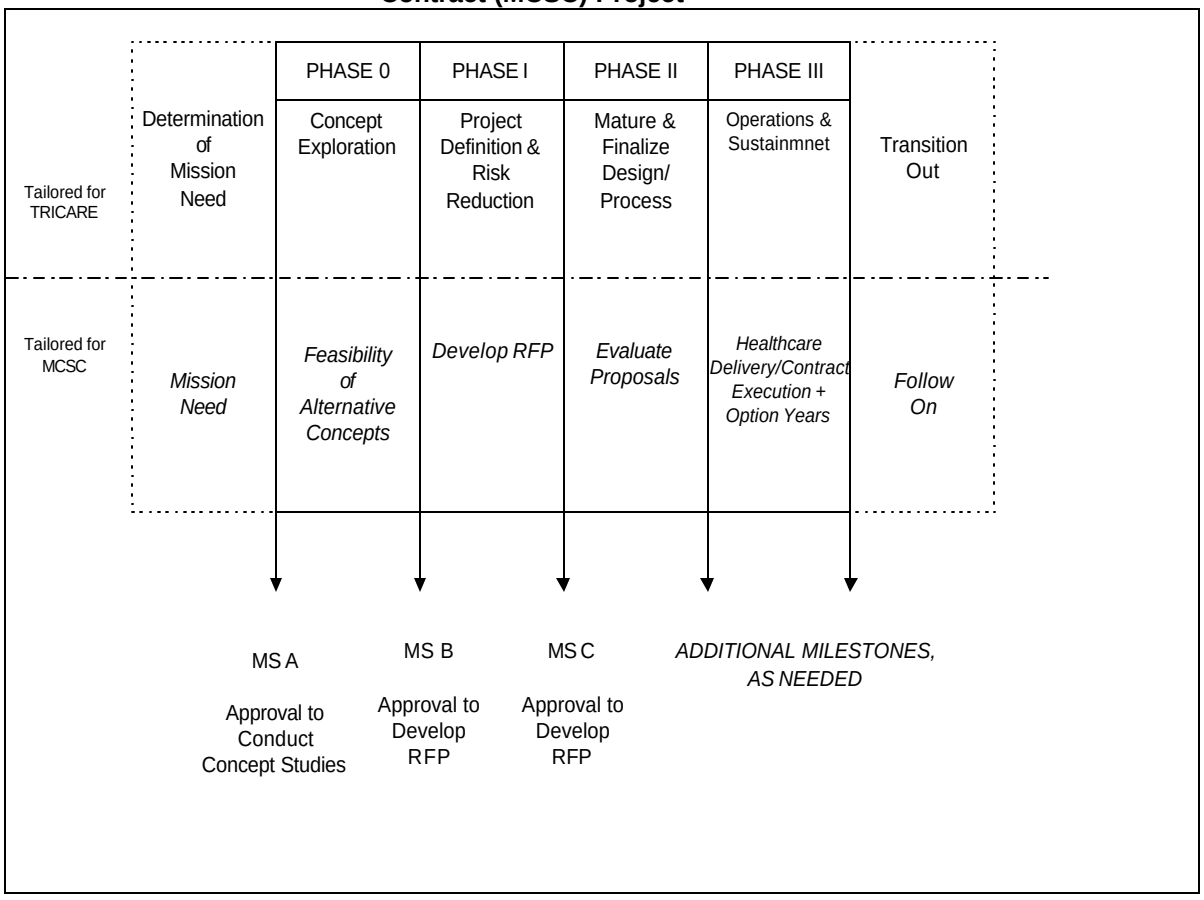
The major activities of the Project will be implemented in a series of four phases:

Phase 0 Concept Exploration
Phase I Project Definition and Risk Reduction
Phase II Mature and Finalize Design and Processes
Phase III Operations and Sustainment

Figure 1.0, Project Milestones, illustrates the “cradle to grave” concept of milestones and the tailoring of DoD 5000.

The phases and milestones of a Managed Care Support (MCS) Project are included to provide some insight into the tailoring process as well as to illustrate the inherent flexibility with the management model. Figure 1 needs to be tailored and some phases may be combined or not applicable.

Figure 6
Tailoring the DoD 5000 Managed Care Support Contract (MCSC) Project



The strategies, plans and activities required to establish the project will be consistent with the overall TRICARE Program goals and guiding principles, as detailed in the TRICARE Program Management Organization Users' Guide.

- *In which phase are you beginning the project?*
- *Will your project proceed through all of the phases?*
- *How will you tailor the DoD 5000 phases to meet the needs of your project?*
- *What are the major milestones for your project?*

A. MANAGEMENT APPROACH

The following is offered as boilerplate text. If specific reporting or oversight direction has been provided, you should add it to this section.

The management approach for the Project will follow a tailored version of the management model detailed in DoD 5000.2R, Mandatory Procedures for Major Defense Acquisition Programs (MDAPs) and Major Automated Information System (MAIS) Acquisition Programs. The DoD 5000.2-R management process is structured in logical phases separated by major decision points called milestones. The process begins with the identification of broadly stated mission needs and translates those needs into a stable, affordable, well-managed project.

At project initiation and after approval of the mission need, the Project Manager (PM) will propose for consideration to the PEO/MDA: the appropriate milestones, the level of decision making for each milestone, and the documentation for each. Changes and recommendations will be coordinated among the PEO/MDA, the Director of PM&I Office, and the Project Manager and subsequently incorporated into the Project Management Plan (PMP). This plan will be submitted to the PEO/MDA for final approval.

In addition to this structured, yet tailored approach, key tenets of the DoD 5000.2-R acquisition management model will be used to integrate essential cross-functional disciplines to optimize project decisions. The cross-functional IPT stakeholders will execute the project. When possible, the IPT will use a consensus decision making process.

B. MIGRATION STRATEGY (if applicable)

- *Has this requirement been provided in another capacity?*
- *If so, how will you transition implementation to the new design?*
- *Will there be impacts on current systems, procedures, policies, etc.?*

If the requirement met by the project is currently being provided, describe the process necessary to migrate to the new solution. Identify elements that will be affected by this change (such as information systems). Describe how you plan to move the requirement from the old to the new process.

If this is a brand new requirement, not being fulfilled by any other mechanism, this section is not applicable.

C. ACQUISITION STRATEGY (if applicable)

The following questions should be considered when developing this portion of the Project Management Plan. Keep in mind that this is not a detailed Acquisition Plan. An Acquisition Plan may be necessary; however, it will be detailed later.

This section is meant to be the overarching strategy. The following questions may prove useful in getting started.

- *Is a non-material solution available? Will a policy change meet the requirements?*
- *Do existing contracts exist that are potentially in scope, e.g., indefinite delivery/indefinite quantity contracts, contracts accessible through GSA Schedules, etc.?*
- *Is the DoD authorized to use these existing contracts?*
- *When will a detailed Acquisition Plan be drafted?*
- *Who will prepare the Acquisition Plan?*
- *Will an Acquisition WIPT be established for other activities? If so, who is required to participate as a member?*
- *Are there legal issues that need to be resolved?*
- *Is the value of the work large enough to require formal source selection procedures?*

D. PROJECT INTEGRATION

The PM&I Office is responsible for compiling and analyzing information from all of the TRICARE Programs. PM&I will build and maintain systems that will store all documents, schedules and data for all projects, enabling the TRICARE PEO and Director, PM&I to:

- Identify opportunities for project collaboration when desirable;
- Identify the program's impact on TRICARE; and
- Identify the program's impact on the overall TRICARE Program.

The Director reports regularly to the TRICARE PM on the interrelationships, schedule conflicts, project status, etc.

If you know of any existing integration, please provide a list and description of how your project will affect/depend upon/interact with, etc. the other projects. The tools that are used for integration, such as Primavera and the Integration House, should also be mentioned.

V. DATA STANDARDS

The following questions should be used as a starting point to document this section:

- *Will the project impact any existing information systems, e.g., CHCS, DEERS?*
- *Will the project require a new information system?*

- *Are there any Health Insurance Portability & Accountability Act (HIPAA) standards that apply to my project?*
- *Will any data be considered confidential? Classified?*
- *Are there any special reporting requirements, e.g., GAO?*
- *Have you coordinated new technical requirements with the Functional Integrated Workgroup (FIWG) within the Information Management, Technology and Reengineering (IMT&R) Directorate?*

VI. CAPABILITIES REQUIREMENTS

Identify the program's required operational capabilities in terms of performance parameters or functional requirements. Articulate requirements in operational, output-oriented, and measurable terms, i.e., metrics, project performance parameters. If possible, specify each performance parameter in terms of a minimum acceptable value (threshold) required to satisfy the mission need. Objectives for each performance parameter should represent a measurable, beneficial increase in capacity or operations and support, above the threshold value. The timing of requirements should specify the time-based nature of the need and any events that are driving the need.

- *What means will be employed to measure the success of your project? What are your project metrics?*
- *Are there standards to which the project must adhere?*

Key Performance Parameters (KPPs) are system capabilities or characteristics considered essential for successful mission accomplishment. Failure to meet KPP thresholds may cause the project to be reevaluated or terminated. Below are steps to one methodology for developing KPPs:

- *List required capabilities for satisfying the mission need;*
- *Prioritize these requirements;*
- *For each function, build one measurable performance parameter;*
- *Determine the parameters most critical to project success and designate as the KPP.*

VII. SCHEDULE OF ACTIVITIES

Insert a schedule that identifies high level tasks to be completed. Also identify the major milestones, as well as the exit criteria for each milestone. Information in this section should complement the project Milestone Chart.

VIII. RESOURCE REQUIREMENTS (if known)

A. LABOR

List the labor requirements to complete each phase of the project. Provide information in hours, person years, or full-time employees (FTEs) and break out by labor category such as senior project analyst, clinician, data processor, etc.

- *Is special assistance needed during the PMO process, e.g. business case analysis, etc.?*
- *What staffing will be required to sustain the project after implementation?*

B. FUNDING

- *What is the required funding for the project by phase?*
- *Has funding been approved for Project Implementation?*
- *What funding stream has been identified?*
- *Have appropriate documents, e.g. POM Fact Sheets, Form 789, been submitted for action?*

IX. RISK ASSESSMENT

A. TECHNICAL RISKS

Identify technical risks associated with incorporating the Project into the overall TRICARE Program. These risks may include the technologies necessary to incorporate the project into the Information Systems currently in place. This section should also address risk mitigation efforts that will be undertaken. Typical technical risk mitigation actions may include system change reviews and analysis. Other technical risks may involve aligning Managed Care Support Contractors' business practices and contracts with the new requirement.

B. PROGRAMMATIC RISKS

Identify the risks associated with obtaining and using resources, including personnel resources and funding resources, to support activities under the control of the PM. Include the subsequent risk mitigation efforts.

1. Cost Risks

Identify the cost risks related to instability in project growth, programmed funding cycles, and costs driven by the marketplace. Potential mitigation strategies include cost and budget metrics, requirements, stability and growth metrics, realistic cost estimations, and routine analysis of the marketplace influences on the program's progress.

2. Schedule/Performance Risks

Identify schedule risks associated with schedule slippage within the project life cycle and in related projects. Mitigation strategies include schedule metrics, use of incremental development and delivery activities, and application of realistic estimation processes for planning project activity. Performance risks include those associated with the contractor performance and the ability to meet the performance expectations or the project requirements. Contractor Performance/Client Satisfaction involves client support, performance, and reliability.

X. APPROVALS:

Project Manager	**Date**
Co/Deputy Project Manager (if applicable)	**Date**
TRICARE Program Executive Officer	**Date**

Appendix C:
Alpha Contracting

I. WHAT IS ALPHA CONTRACTING?

Alpha contracting is a transition from a consecutive contracting process to a concurrent contracting process. A team approach is used to definitize requirements, develop a rough order of magnitude (ROM) and then negotiate the final contract. The primary advantage of alpha contracting is a shorter timeframe for contract award. The contractor is involved early in the process and participates in the roundtable discussions on project requirements. Far fewer revisions and lags between revisions are required.

A major paradigm shift for TMA will be making bilateral supplemental agreements rather than unilateral changes the standard business practice. This shift will entail a more costly and labor intensive process on the front end due to travel requirements and the heavy focus on joint negotiation sessions; however, the improvement in communications and the overall streamlined process will outweigh these drawbacks.

The alpha contracting team, referred to as the pricing IPT, will work together to define the scope and price of the work and prepare the contract modification. The pricing IPT membership and responsibilities are outlined in the table below.

PRICING INTEGRATED PROJECT TEAM (IPT)	
Project Manager (PM)	Ultimately responsible for ensuring contract modifications adhere to project requirements.
Contracting Officer (CO)	Acts as lead government contracting representative.
Pricing Analyst	Assists IPT in evaluation of proposal.
Change Cycle Manager	Facilitates the pricing IPT to ensure reasonable timetable maintained.
Defense Contract Audit Agency (DCAA)	Advises IPT on government contracting guidelines and constraints, as needed.
Office of General Counsel (OGC)	Advises IPT on legal ramifications, as requested.
Lead Agent (LA)	Provides direct care and MTF specific perspective
Technical Representative(s)	Consult the IPT regarding technical specifications of contract change. Could include independent estimators or government Contracting Officer Representatives (COR's).
Managed Care Support Contractor (MCSC) & Principal Subcontractors	Provide on-going real time feedback on costs and implementation plans for project requirements and contract modifications.
Contract Administrator (CA)	Supports Contracting Officer as requested.
Defense Contract Management Command (DCMC)	Advises IPT on evaluation of proposal in terms of government requirements and contractor capabilities, as needed.

II. Alpha Contracting Process

The alpha contracting process begins after the Change Management Board (CMB) approves the change request for implementation. The previously developed joint rough order of magnitude (JROM) forms the basis of the process.

1. Change Cycle Manager and CO receives the approved change package and funding documents (DD789).

2. Timelines set with the MCSC(s) and Pricing IPT.

3. Request for Proposal (RFP) issued.

4. Technical review.

5. On-site fact finding. (Documentation of activities becomes a part of the proposal.)

6. CO and team begin negotiations with MCSC(s).

7. Post-Negotiation Memorandum (PNM) finalized.

8. CO presents to Contract Management Board of Review, if required.

9. Submission to Office of General Counsel (OGC) for legal review.

10. Supplemental Agreement

III. Characteristics for Successful Alpha Contracting

- Commitment to the process.
- Involvement of all parties from the start.
- Combined technical and contracting functions resulting in a seamless process.
- Dissection of the total effort into workable & understandable pieces.
- Willingness of the government and contractors to challenge existing processes and strive for changes.
- Cultivation of a working atmosphere that fosters honesty and trust.
- Acceptance of joint ownership of the process and responsibility of its success.
- Understanding of a team focus with a common purpose, vision and desired outcome.
- Empowerment of team members to make agreements during contracting process.

Appendix D:
Change Management
Frequently Asked Questions

CHANGE MANAGEMENT
Frequently Asked Questions (FAQs)

Q. How do I get on the agenda to brief the various approving bodies, e.g. Change Management Board (CMB), Health Services Delivery Steering Group (HSDSG)?

A. Contact the Program Management & Integration (PM&I) Office to schedule a briefing. They facilitate the change management process and will schedule the appropriate brief. They will also advise you on briefing content, structure and format.

Q. After my change package is approved by the Change Management Board (CMB) how do I request the release of funds?

A. A copy of the minutes from each Change Management Board (CMB) meeting is forwarded to the Resource Management (RM) Directorate who then processes Form 789. This form is forwarded to Contract Management and authorizes them to begin work on the change request.

Q. How do I request participation from the managed care support contractors (MCSC)?

A. Work through the Contracting Officer (CO) in Aurora assigned by the Acquisition Management and Support (AM&S) Directorate to your project for managed care support contractor (MCSC) participation. The CO is the only government personnel authorized to contact the MCSC.

Q. Where do I get Project Fact Sheets?

A. Project Fact Sheet templates can be downloaded from the TRICARE website *http://www.tricare/pmo/info/templates.html*.

Q. What is an independent cost estimate and how do I request one?

A. An independent cost estimate is a cost estimate provided by any source other than the managed care support contractor (MCSC). It is used to gauge the validity of the MCSC's estimate. Contact the Resource Management (RM) Directorate to identify the Contracting Officer Representative (COR) responsible for the contract. They will explain the process and documentation necessary to request an independent estimate.

Q. What is a contractor Rough Order of Magnitude (ROM) and how do I develop one?

A. A contractor rough order of magnitude is a cost estimate developed with participation from the government and the managed care support contractor (MCSC). Begin by forming an integrated project team (IPT) to develop a framework or draft of your project requirements. Contact the Contracting Officer (CO) for your project when you are ready to bring the MCSC into your meetings. Although cost estimates obtained at the end of the process should be very close to actual, keep in mind that the objective of the ROM process is to gain agreement on project requirements not to negotiate price.

Q. What is the difference between a Rough Order of Magnitude (ROM) and a contractor Rough Order of Magnitude (ROM)?

A. A rough order of magnitude (ROM) is developed for concept approval. It is a very rough cost estimate and does not necessarily include input from a formalized integrated project team (IPT) or the managed care support contractor (MCSC). A contractor ROM is a far more accurate cost estimate formulated in cooperation with an IPT and the MCSC.

Q. How do I formulate a cost estimate for my project?

A. A contractor rough order of magnitude (ROM) and independent contractor cost estimate are two tools to assist the Project Manager in cost estimation. Additionally, contract staff may be consulted.

Q. What if the project's negotiated final cost is significantly higher than the estimate approved by the Change Management Board (CMB)?

A. During all phases of project development close attention must be paid to variances in cost. If the difference between approved Change Management Board (CMB) funding and the contractor's negotiated final cost is greater than 10%, you will be required to go before the CMB to justify the need. Additionally, the Contracting Officer (CO) will advise if negotiations need to be halted due to cost overruns.

Q. My project has been approved by the Change Management Board (CMB) however it won't be implemented/funded until an out-year. What do I do?

A. In the interim, continue to review the costs of your project to ensure funding and/or project requirements do not change significantly. Also, contact the Program Management & Integration (PM&I) Office to verify your project is submitted for the Program Objective Memorandum (POM) process accurately. Remember -- the project status is the Project Manager's responsibility until it is implemented and becomes 'normal business'.

Q. How is the managed care support contractor (MCSC) reimbursed for contractor rough order of magnitude (ROM) development?

A. A cost reimbursable contract line item (CLIN) has been incorporated into the managed care support contract. Government contracting staff will issue task orders against this CLIN for contractor ROM funding.

Appendix E:
Program Objective Memorandum
Fact Sheet

PROJECT NAME

PROJECT MANAGER (Name, Office Symbol, and Phone)
DATE PREPARED

DESCRIPTION: A brief, one-paragraph description of this project

BENEFICIARIES IMPACTED: (all, AD, ADFM, AD-TPRFM, >65, <65 retirees, etc)

GOVERNING REQUIREMENT DOCUMENT: (Reference Legislation & Section, or other documentation
that directs or mandates this project)

IMPLEMENTATION MODE: (Managed Care Support Contract, Other contract (specify), Service Direct Care
system (specify if appropriate), combination (if a combination break out at Purchased Care and Direct Care
in the cost estimate, etc.)

KEY DATES:

OTHER: Any other information or background that is important to the project

PRICING ($ in Thous):

Required

	FY01	FY02	FY03	FY04	FY05	FY06	FY07
O&M-MCSC							
O&M-Dir Care							
O&M-IMIT/Other							
O&M Coast Guard							
O&M Other Non-DoD							
Procurement							
RDT&E							

Funded

	FY01	FY02	FY03	FY04	FY05	FY06	FY07
O&M-MCSC							
O&M-Dir Care							
O&M-IMIT/Other							
O&M Coast Guard							
O&M Other Non-DoD							
Procurement							
RDT&E							

Requested Adjustment (Required – Funded)

	FY01	FY02	FY03	FY04	FY05	FY06	FY07
O&M-MCSC							
O&M-Dir Care							
O&M-IMIT/Other							
O&M Coast Guard							
O&M Other Non-DoD							
Procurement							
RDT&E							

Recommended Offset

Project Title	FY01	FY02	FY03	FY04	FY05	FY06	FY07

Requirement Cost Definition Summary (attach IGCE or other detailed documentation—sub-bullets below must be completed):

MCSC IGCE ($K)	FY01	FY02	FY03	FY04	FY05	FY06	FY07

Assumptions

Methodology

Data Source (IGCE, JROM, ROM, Other). For MCSC items—if IGCE is available, but not used in requirement section, quantify and explain the difference between the current estimate (required) and the IGCE.

SERVICE SPLIT RECOMMENDATION: Specific split or recommended methodology for split between Services **must** be provided regardless of mode of implementation (MCSC, MTF, etc).

COST RISKS: Explain factors or possible situations that may invalidate cost estimate.

COST ESTIMATE CONFIDENCE FACTOR: (100% = firm estimate/known costs, percentage declines with confidence in its accuracy)

IMPACT IF NOT FUNDED:

Project Manager Coordination: _____
(signature and date)

Project Sponsor Coordination: _____
(Service RM, or TMA Director signature and date)

Appendix F:
Integrated Program Team (IPT) Charter Instructional Template

CHARTER

Military Health System (MHS)

<Name of Project>

1. **Purpose**
   Briefly, in one or two sentences, state the purpose for this project being established.

2. **Scope of Activity**
   In a few sentences, outline the major focus or activities that this IPT will be working on.

3. **Membership**

Title, Organization / Service, Division/Directorate	Chair
Title, Organization / Service, Division/Directorate	Member
Title, Organization / Service, Division/Directorate	Member
Title, Organization / Service, Division/Directorate	Member
Title, Organization / Service, Division/Directorate	Member

4. **Meetings**
   Describe how meetings will be held, i.e. who hosts them, how often they will take place, etc.

5. **Deliverables**
   List the major deliverables that will be generated by this IPT, to include the Core Documents, other supporting documentation, any products that result from this effort, etc. If minutes are produced from IPT meeting and/or WIPT meetings, cite that as well.

6. **Duration**
   Cite how long this IPT is going to last, e.g., a certain period of time or at the discretion of the PEO. If closure of this IPT is dependent upon a final deliverable, cite the deliverable.

LEONARD M. RANDOLPH, JR., MD
Major General, USAF, MC
Deputy Executive Director

Appendix G:
Milestone Chart Explanation
and Instructional Template

Explanation of Milestone Template

The milestone chart should be updated monthly and included with information papers and all IPT status briefings*.*

The following must be added to the chart:

- **Start Date:** this is the date the Project Manager appointment letter was signed
- **Projected End Date:** projected date the program will be implemented or completed
- **Shade the Current Phase:** shade (in gray) the current phase of the project
- **Check Mark Completed Tasks:** put a check mark bullet on the items in the shaded area (current phase) that have been completed
- **Decision Points:** list the items/tasks requiring a decision from leadership/Services. Include a 'no later than' date (NLT MM/YY)
- **Current Issues:** list the current issues that the project is facing. Denote each of the current issues with a

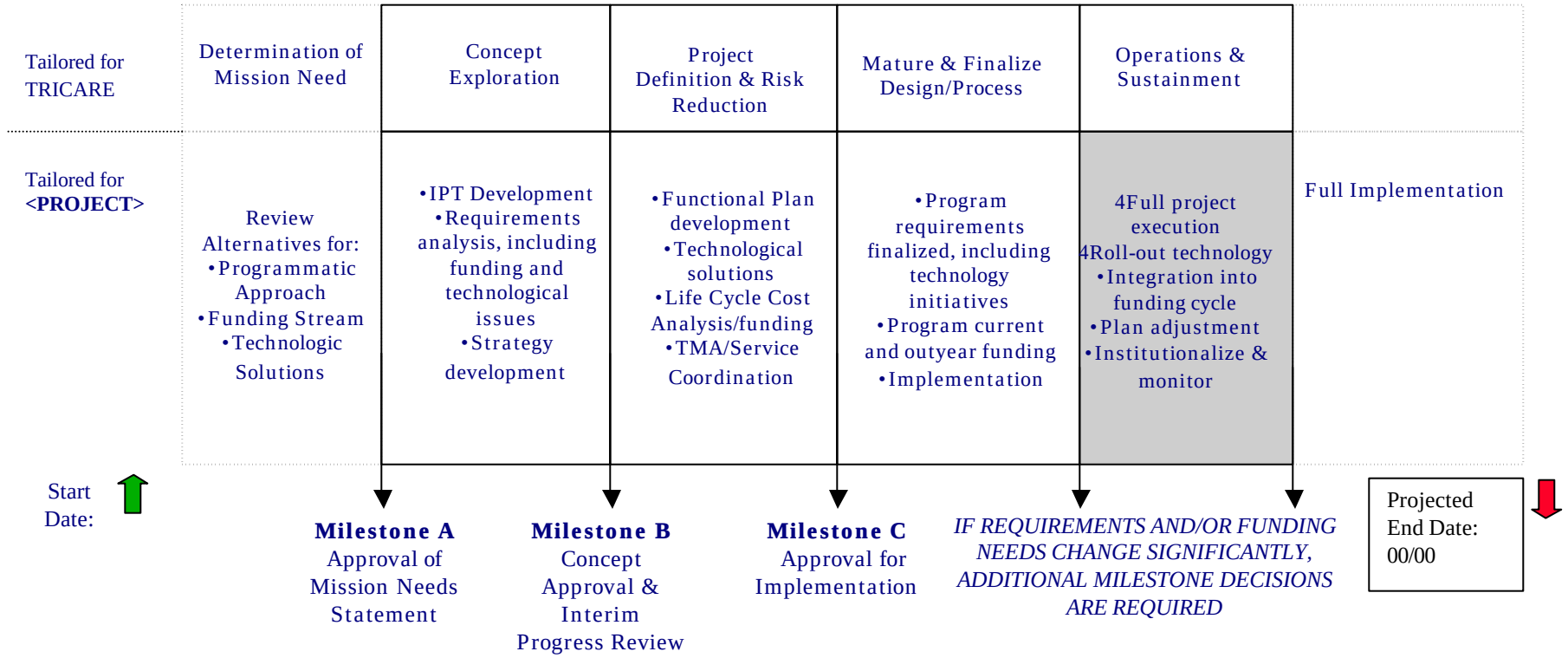
  Green circle if the issue(s) won't stop the program

  Yellow circle if the issue(s) may stop or slow down the program

  Red circle if the issue(s) will stop the program if not addressed

NOTE: Upon completion of the milestone chart, the explanation page may be deleted.

<Project Name>
Milestone Chart
(Template)



Decision Points:

1. Example
2. Example

Current Issues:

- Example
- Example

Legend: 4 Task Completed | On Going | Caution | Progress Stopped | Current Phase